States of Guernsey
BOARD OF HEALTH

104th ANNUAL MOH REPORT

NINTH ANNUAL DPH REPORT

Special Theme:

'The Quality of Clinical Care in Guernsey'

REPORT FOR THE YEAR 2002/03

BOARD OF HEALTH

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Front Cover

An increasing number of cancer treatments are given at day patient chemotherapy clinics in the newly refurbished Bulstrode House Oncology Unit as part of the ongoing implementation of the *'Guernsey Cancer Strategy'*.

Structured cardiac rehabilitation following heart attacks, heart surgery and in some forms of heart failure can speed the return to normal activities, and substantially reduce future readmissions and overall mortality. The Guernsey Cardiac Action Group organize regular cardiac rehabilitation courses at the *'Guernsey Chest and Heart Association'* premises on the Princess Elizabeth site.

Pictures courtesy *Health Promotion Unit.*

STATES OF GUERNSEY

BOARD OF HEALTH

Objectives

To maintain and improve the health of the people of Guernsey and Alderney by:

- identifying health needs – now and in the future;
- planning the future provision of health services to meet these needs;
- ensuring provision of these services through direct provision, commissioning or indirect influencing;
- ensuring that the quality of health service provided is high through clinical and corporate governance;
- ensuring that only appropriate care or treatment is given, by comparing with best practice standards and other providers;
- ensuring that care and treatment is effective by monitoring the outcome of such interventions;
- listening to the customers in order to understand their needs and working with others so as to best meet these needs;
- informing people on health matters, promoting a healthy lifestyle and environment;
- acting as a 'caring neighbour' and considering the environment for future generations;
- checking that all health services provided are as cost-effective as possible;
- acting as a good employer;
- recruiting, training and developing sufficient healthcare staff;
- valuing the staff and helping them to meet their needs and aspirations.

INTRODUCTORY LETTER TO THE BOARD OF HEALTH

October 2003

The President
States of Guernsey Board of Health

Dear Sir,

I have pleasure in submitting the 104th Annual Report of the Medical Officer of Health for Guernsey for 2002/2003.

Yours faithfully,

Dr David Jeffs
MEDICAL OFFICER OF HEALTH
Director of Public Health

Executive Summary

- According to the latest estimates, total States and private health related expenditure exceeds **£83m**, or around **£1,394** per capita annually. The Board of Health alone receives over **24%** of the total States revenue expenditure.
- The Board of Health therefore considers it important to be able to demonstrate that the quality of clinical care delivered locally is generally high, and that a more strategic approach to health investment is helping improve health outcomes and producing better health more generally.
- The Board is pursuing these joint objectives through the implementation of *'clinical governance'* and through new health investment being targeted towards the six chosen health priority development areas.
- Under the *'clinical governance'* structures already implemented at the Princess Elizabeth Hospital, we can now be reasonably confident that in those clinical areas which have been audited - acceptable or superior levels of clinical care can generally be demonstrated.
- The next challenge must be to ensure that similar structures and processes are developed to cover all Board of Health activities, and over time to also be able to demonstrate similar high standards in primary care and community based practice.
- Under the 'health priorities' initiative, mortality from the leading cancers and overall cardiovascular mortality can be demonstrated to have fallen substantially over recent years. In both these areas, mortality in Guernsey is considerably lower than published levels for Britain. It is hoped that further investment will allow these trends to continue.
- It is also hoped that as our health information systems improve, further strategic investment in the other priority areas of mental health, elderly care, children's services and learning disability services will be able to demonstrate steadily improving health outcomes in these areas.
- Unlike UK health authorities, the Board of Health has traditionally been responsible for environmental health. The enactment of the *'Control of Pollution'* law in the near future will mean that responsibility for these aspects of environmental control will become independent of the Board of Health.
- For the first time since the Occupation years, deaths in Guernsey have exceeded births, i.e. the island has a negative *'natural increase'* of population and without net immigration would show a stagnant or falling population.
- As well as fewer births, Guernsey women are choosing to have their children later in life. More women aged 30-34 years now give birth than those aged 20-29 years. Happily teenage pregnancies (those <20 years) have also shown their third successive annual fall, and are now 25% lower than in the year 2000.

CONTENTS

Acknowledgements:

Many people contribute towards the improving health of our population.

I particularly wish to thank all public health directorate staff, to the many others who contribute to public health initiatives, to the several contributors and particularly to my PA Mrs Yvonne Kaill and to Mrs Jenny Elliott who helped collate and produce this Report.

Dr David Jeffs
Director of Public Health

Chapter One

The quality of clinical care in Guernsey

Health and healthcare is a costly business in Guernsey.

The Board of Health receives the largest single share of States expenditure (currently 24.2% of the States' total Revenue Account), and it is also the largest single employer on the island.

Additional States' health expenditure channelled through the Guernsey Social Security Authority (GSSA) includes the Health Insurance contract with the Medical Specialist Group, prescription subsidies through the Pharmaceutical Benefit Scheme, doctor and practice nurse rebates, and assistance with medical travel expenses.

There are also additional individual health expenses, including the cost of private health insurance, the balance of primary care fees, travel vaccinations, and the 'standard' prescription charge for other medications.

According to the most recent *'Sustainable Guernsey'* Report (Advisory and Finance Committee 2003) Guernsey spends £1,394 per capita annually on health - well above the UK and close to the average for European health expenditure.

But how good a health service do the people of Guernsey receive in return for this significant investment, and how can we demonstrate the quality of such clinical services locally'?

Medical mishaps and near misses

When an aircraft has a 'near miss', this almost invariably makes 'front page' news, whilst any aircraft accident leading to loss of life will be thoroughly investigated and the lessons learnt rigorously applied to preventing similar mishaps occurring in the future.

Yet until fairly recently, there was often a feeling that when something went wrong in healthcare, it was *'just one of those things'*. Occasionally a patient (or their relatives) might decide that a particular doctor, healthcare worker or hospital had been negligent, and lengthy (and often unsatisfactory) legal proceedings might ensue.

However, a recent *'catalogue of medical disasters'* has served to challenge this view.

A 'maverick' gynaecologist continued to practise for years despite a long history of unsatisfactory results, neonatal cardiac surgery at the Bristol Royal Infirmary consistently showed poor outcomes when compared with other tertiary centres, 'stored organs' at the Alder Hey Children's Hospital in Liverpool were a cause of distress to many parents and 'outrage' in the media

These events and others have forced health professionals, politicians and the public to both question *'what has gone wrong?'* and more importantly to ask *'why?'*.

As with most airline crashes, the answers are inevitably complex, but are much less often due to individual error or incompetence, and far more likely to be due to a 'systems failure'. For example, the poor results of the 'maverick' gynaecologist had been well known to many of his colleagues, but they felt constrained to act because he was working across several hospitals, and largely outside the administrative framework of the NHS.

The poor results of paediatric surgery in Bristol had been reported to both the hospital management, and the Department of Health in London several years before action was finally taken.

The legal issue of who 'owns' pathological tissue is far from clear, and 'pathological museums' in hospitals throughout Britain have traditionally retained abnormal tissue for teaching and research purposes. Sometimes, these provide essential information which could not have been obtained in any other way - for example the emergence of HIV some ten years before it was clinically described and the risk of passing on new variant CJD through surgical instruments exposed to infected lymphoid tissue both relied on 'historical' tissue samples.

Faced with the need to address such complex issues, the UK Government through the Department of Health and the health professions through the General Medical Council, the Medical Royal Colleges and other professional bodies jointly agreed on the need to introduce *'clinical governance'* across all clinical services.

What is *'clinical governance'*?

There are many definitions of 'clinical governance' but in essence the concept is a simple one - that all staff providing clinical services should accept their shared responsibility for the quality and outcomes of these services, and be willing and able to demonstrate them as such.

'Clinical governance' is therefore an umbrella term, which covers a number of separate components - sometimes referred to as the *'seven pillars of clinical governance'*. These include:

- clinical information
- clinical audit
- clinical risk management
- research and effectiveness
- staffing
- education and training
- patient and user involvement.

Since April 2001 all NHS Chief Executives in both hospital and Primary Care Trusts have had a statutory duty to report on clinical standards and outcomes in the same way as they have traditionally reported financial outcomes.

To ensure compliance across the NHS, a whole new layer of health bureaucracy with a range of somewhat confusing acronyms has been created. NICE (*National Institute for Clinical Excellence*) examines 'evidence', and sets clinical standards. *CHI* (the *Commission for Health Improvement*: shortly to become *CHAI '(Commission for Healthcare Audit and Inspection')* 'inspects' hospitals on a four yearly rolling programme, and ensures compliance with preset standards.

The *NPSA (National Patient Safety Agency)* is a special Health Authority created in July 2001 to co-ordinate efforts to report, and more importantly learn from, adverse events occurring in NHS funded care.

More controversial are the hospital *'league tables'*. Following CHI assessment, hospitals are ranked as three, two, one or 'no star' hospitals. Those achieving 'three star' status have been promised the opportunity to become *'Foundation Trusts'* with a high degree of autonomy, whilst those with 'no stars' are deemed to be *'failing'* with the threat of replacement of Chief Executive and entire Board if no improvement can be demonstrated within twelve months.

Structures for *'Clinical Governance'* in Guernsey

Although Guernsey health services do not form part of the NHS, and there is no statutory requirement for them to comply, the Board of Health and local health professionals are united in their belief that local health services should at least match, and preferably exceed those provided under the NHS, and that we should have structures and mechanisms to be able to demonstrate them as such.

However, health services in Guernsey have grown up in a very different way, and rather different approaches are therefore necessary to achieve and demonstrate the quality of clinical services provided.

It is also important to continually remind ourselves that our structures for ensuring clinical quality must be appropriate to the island populations of around 63,000, and should recognise the independence of the Medical Specialist Group, Guernsey Physiotherapy Group and primary care group practices. We do not need to replicate NHS structures, but rather adapt them to reflect the real differences in the Guernsey health system. Local developments under the *'seven pillars'* approach therefore include:

Clinical information

Good quality documentation - particularly the content of the patients' health records, is essential for good clinical governance. Without proper documentation, *clinical audit, clinical risk management* and many other clinical governance activities are without adequate foundation.

Most health professionals now accept the need to achieve and maintain high levels of medical record keeping. Levels of record keeping in Guernsey have historically not been of the highest standard. To make best use of such information, high quality clinical coding is essential. Guernsey is fortunate in having two well-trained and experienced clinical coders who form part of the Public Health Directorate.

A recent independent audit of the quality of clinical coding showed accuracy levels of more than 90% - comparing very favourably with much larger institutions.

The Board of Health is also committed to introducing an *'electronic patient record'* within the next five years. This will ensure more speedy availability of important clinical information between attending clinicians and specialist departments, such as radiology, pathology and pharmacy - whether based at the PEH, MSG, primary care or other non-hospital sites. It is essential that high standards of clinical record keeping are achieved and maintained before finally 'going electronic'.

Clinical Audit

Clinical Audit is the process of comparing local practice and outcomes against national or other recognised standards, identifying opportunities for improvement, implementing these and completing the *'audit cycle'* by re-auditing at a later date.

Clinical audit is co-ordinated in Guernsey by the *Clinical Audit Committee* and preferentially supports audits:

- which address causes of high morbidity, high mortality or high healthcare expenditure
- where recognised national or professional standards exist
- which are multidisciplinary in scope and involve all members of the 'healthcare team'.

In all, some **25** clinical audit projects were completed during **2002**, whilst a further **10** were ongoing. Recent major clinical audit activities undertaken in the past year include.

- MINAP (Myocardial Infarction National Audit Project)

This allows management and outcome of 'cardiac episodes' treated at the PEH to be compared with participating hospitals throughout the UK.

An essential to improved outcome is the rapid administration of thrombolysis *'clot busting'*. In Guernsey **60%** of patients eligible for immediate thrombolysis received this within 60 minutes of calling for professional help. The national average for the year 2002 was **38%**.

With regard to the management of heart failure, as yet there is no accepted data collection format, but recommended *'key investigations apart from echocardiogram were carried out in at least **90%** of cases in Guernsey'*.

- **National Sentinel Audit of Stroke**

This was established *'to identify variables in the organisation of and delivery of multidisciplinary services for stroke and to promote quality, improvement and consistency in the standard of care.'*

Some **235** sites (including Jersey and the Isle of Wight) submitted data collected on **8,200** patients (including **20** from Guernsey). Guernsey scored in the lower mid range for organisation, but in the upper range for care given.

- **Breast cancers**

The results of breast screening between 1992 and 2002 have been examined using the BASO (British Association of Surgical Oncologists) database. This shows that the Breast Screening Unit has detected over **100** new cancers during this period, and with its higher Screening age of 75 years, and two yearly recalls, proportionately more than UK centres. There is a particularly high detection rate for small cancers and 'interval cancers' occurring between the two yearly screens.

- **Pharmacy Care**

Dispensing errors, clinical activity, pharmacy interventions and 'near misses' are audited against recognised standards of practice. Recurring problems demonstrated can then be addressed through the various Clinical Risk Management Groups.

Academic Half Day

It is not intended that 'clinical audit' reports remain on the shelf, but that they are actively used to identify and improve local clinical standards. To help achieve this, selected clinical audit projects are presented at a monthly *'Academic Half Day'* to which a range of involved clinical staff are invited.

It is felt that to have clinical audit projects debated in open forum by colleagues and peers ensures high standards of presentation and an adequate academic rigour.

It is reassuring that audit projects presented at Academic Half Days confirm that clinical standards in Guernsey are generally high, and meet or exceed accepted national standards. For example;

- **Colonoscopy**
  An audit of **653** cases of colonoscopy bowel examination showed over **90%** success with over **30** new cancers detected. During 2002, success rates rose to **97%** (national standard **90%**).

- **Transrectal ultrasound**
  Transrectal ultrasound is used to confirm whether a raised prostate specific antigen (PSA) is due to underlying prostatic tumour. The procedure was introduced into Guernsey in **2001**, and **41** cases were performed during the first twelve months. **34** cancers were confirmed, and the patients were able to be offered more definitive treatment. Since there is a **20%** chance that cancers might be missed, the **17** patients who were not shown to have cancer will be kept under continuing review. There were no cases of complications following the procedure in the cases examined.

- **Paediatric diabetes**
  An audit of all **18** children in Guernsey known to have type 1 (insulin dependent) diabetes showed a comparable level of diabetic control with that achieved at the Specialist Diabetic Unit at Southampton General Hospital.

- **Radiological image guided biopsies**
  This is a way of collecting more accurate tissue specimens from glandular tissues such as the thyroid, lymph nodes or salivary glands. In an audit of **31** biopsies performed on **29** separate patients, satisfactory specimens were obtained in over **90%** - approaching the Royal College of Radiology's standard of 95%. As a result, **7** new cases of cancer were confirmed and could be offered more appropriate management.

- **Diagnostic angiography**
  An audit of **54** diagnostic and therapeutic angiograms performed over a twelve month period showed zero complications (national standard **0.5-4%**).

- **Other 'Academic Half Days'**
  Following the success of the main academic half days, academic half days are now also held by mental health practitioners and allied health professionals. A similar approach of ensuring that results of audit are formally presented, open to peer review, and that recommendations arising are translated into changes in practice, provides a further mechanism for demonstrating and ensuring high standards of clinical practice.

Clinical Risk Management

Clinical Risk Management implies studying and learning from that small proportion of cases when things go wrong in healthcare and pro-actively looking at local practice to identify situations where things might go wrong in the future.

Clinical Risk Management (CRM) teams have been established in nine disciplines and meet approximately every two months. The CRM teams are multidisciplinary in nature, and are co-ordinated by the clinical risk manager who reports directly to the Clinical Governance Committee.

Effective clinical risk management requires adequate reporting of clinical incidents and other untoward occurrences. This is unlikely to occur unless there is a *'blame free'* culture across all clinical areas. Recommendations that require changes in clinical procedure can then be referred to the appropriate *Service Provision Teams*.

Staffing, education and training

High quality clinical services cannot be delivered without sufficient staff, appropriately trained and with the necessary skills to meet the changing nature of their roles.

A Staff Development Sub-committee has been set up to monitor all aspects of staff development, including continuing professional development, off-island attachments, and annual professional appraisal.

The General Medical Council (GMC) has recently announced that in order to be awarded a 'licence to practise', all registered medical practitioners will need to demonstrate continuing competence as assessed by the annual appraisal process. Both MSG and States Employed Consultants are committed to meeting this standard.

Nursing staff are also undertaking annual appraisal following one year's service and under our *'clinical governance'* process this will also be extended to all other staff providing clinical services where this does not already occur.

Patient and user involvement

Although not a prominent feature of the past, this will undoubtedly become more important over the next few years as we strive to improve and demonstrate high quality services for users.

Conclusions: How good is clinical care in Guernsey?

There have been huge changes in how clinical care is organised and how it is delivered in Guernsey over the past ten or so years. These include:

- The separation of primary and secondary care, with the formation of primary care group practices and the establishment of the MSG in **January 1992**.
- An initial seven year Health Insurance Scheme commencing in **1996** was replaced in **2003** with a new fifteen year contract with the MSG to include ophthalmic services. There is a parallel contract for supporting physiotherapy services with the Guernsey Physiotherapy Group.

If asked about the quality of clinical services in Guernsey before these changes, an honest answer would have to be along the lines, *'we feel they are good, at least in parts, but generally we cannot demonstrate this'*.

With our evolving local structures for *'clinical governance'* we can now state with some confidence that in those clinical areas which have been audited - acceptable or superior levels of clinical care can generally be demonstrated.

More importantly, we now have structures which will ensure that clinical processes and outcomes are regularly reviewed, so that continuing improvements can be made.

The next challenge must be to ensure that similar structures and processes are developed to cover all Board of Health activities, and over time to also be able to demonstrate similar high standards in primary care and community based practice.

For the time being, the public of Guernsey can be reassured that high standards of care can be demonstrated in many of the areas examined. Staff working in these areas can be proud that their efforts and contributions ensure that this is so.

Figure 2.1
Approximate numbers of new cancers per year
Based on 1999 and 2000 data

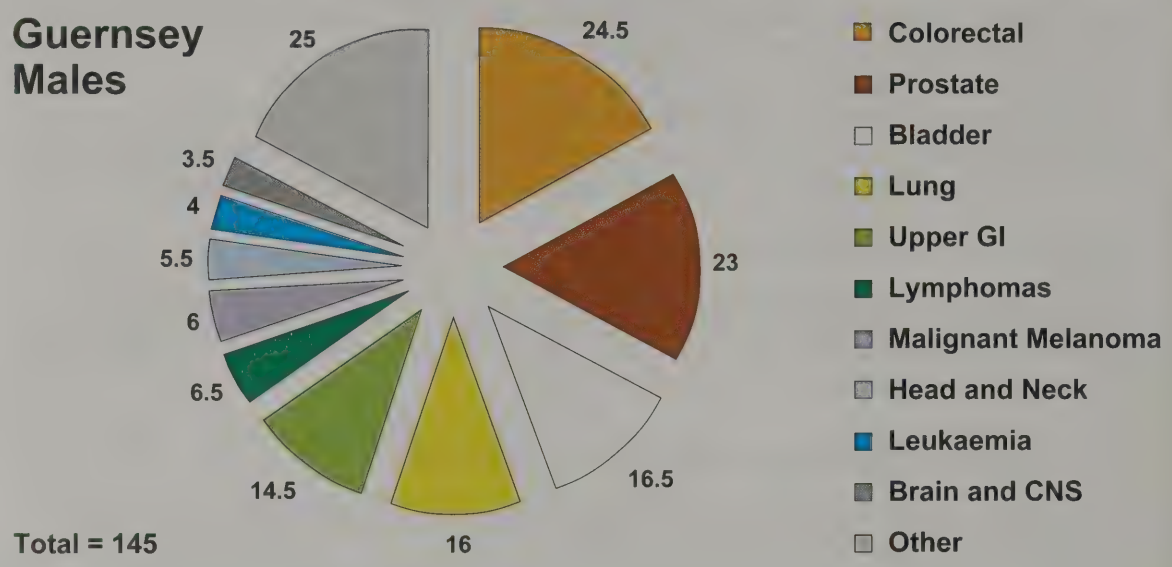
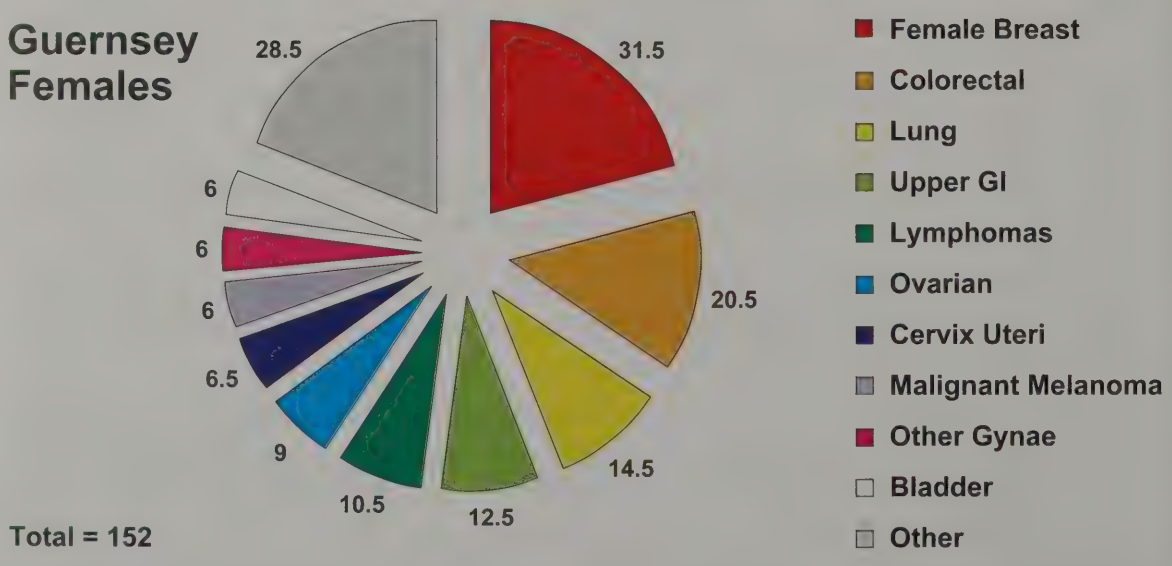


Figure 2.2
Approximate numbers of new cancers per year
Based on 1999 and 2000 data



Source: South West Cancer Intelligence Unit 2000

Chapter Two

Monitoring health strategy

Priority health development areas

In October 2000, the Board of Health agreed to select six 'priority areas' for further health service development on the basis that they were:

- a common cause of death, premature death <75 years, hospitalisation, or a major component of healthcare costs;
- that there were accepted evidence-based national standards such as the various *'National Service Frameworks'* against which to benchmark them.
- there was evidence that further investment would produce measurable improvements in health outcomes at an affordable cost.

On this basis, the following six areas were chosen as 'health priority' development areas over the next 6-9 years:

- cancer services
- cardiovascular disease
- mental health
- services for older people
- childrens services
- services for people with learning disability

Cancer services

Cancers are the second leading cause of death, and the leading cause of premature death (deaths <75 years) in Guernsey. An NHS *'National Cancer Plan'* was published in **June 2000**.

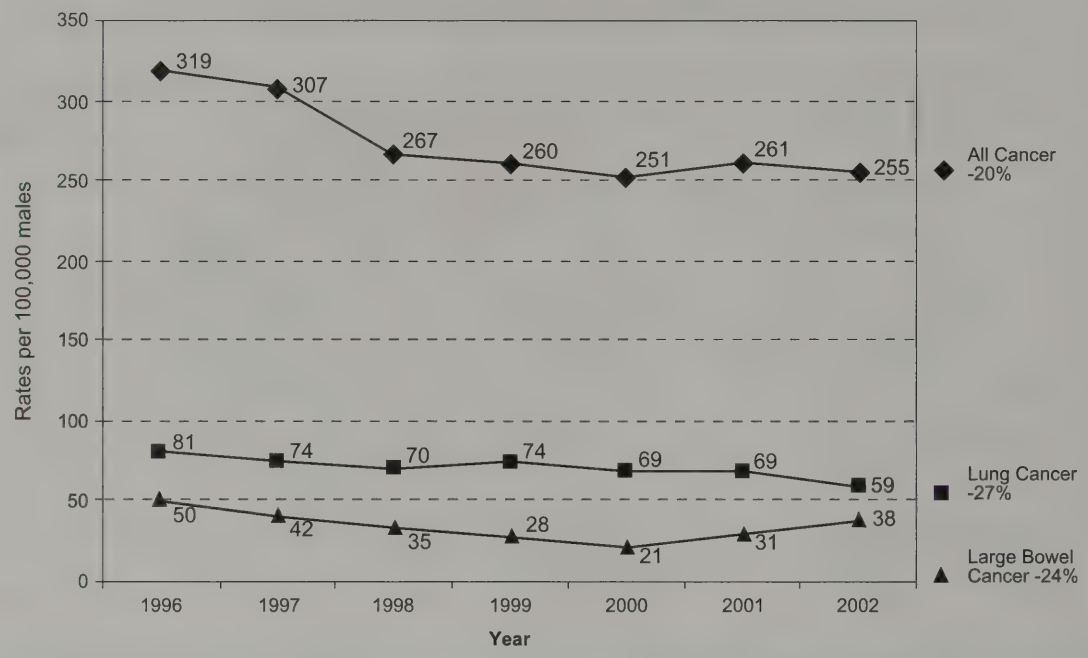
A multidisciplinary group including doctors, nurses, and other health professionals, was first convened in **1997** and met to develop a *'Guernsey Cancer Strategy'* over the next three years. The Board of Health accepted and agreed to progressively impliment the twenty nine recommendations contained in the *'Guernsey Cancer Strategy'* in **June 2001**. Major achievements in meeting these recommendations are as follows:

Progress with the *'Guernsey Cancer Strategy'*

- Guernsey and Alderney continue to contribute towards the Channel Islands Cancer Registry which is part of the South West Cancer Intelligence Service based in Bristol. Data quality continues to improve, and the incidence of new cancers diagnosed amongst Guernsey men and women are shown in *figures 2.1* and *2.2*.

Figure 2.3 - Changes in total and individual cancer mortality Guernsey males - 3 Year rolling averages 1994-2002

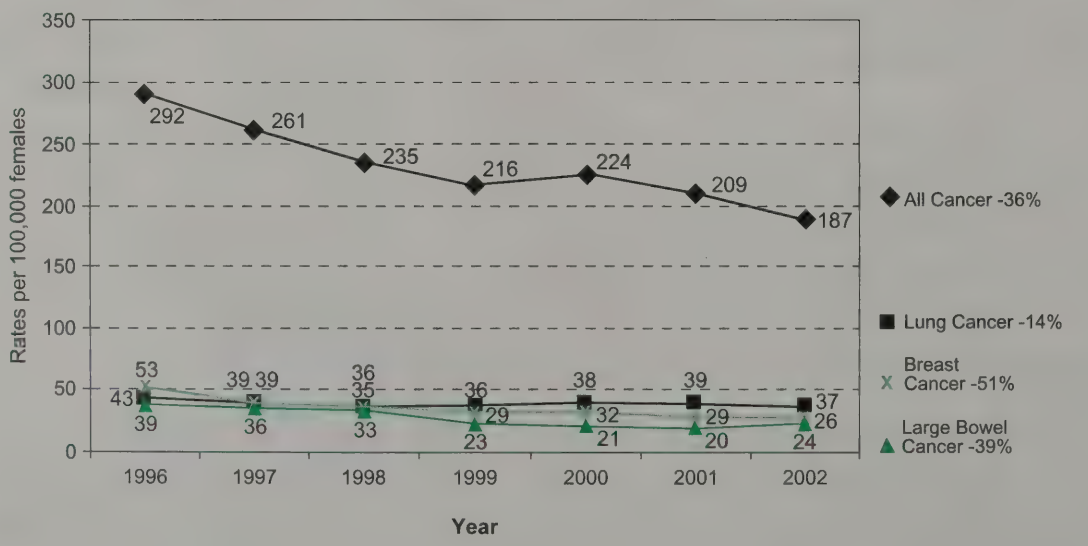
rates per 100,000 resident males



Source: MoH Reports Guernsey 1994-2002

Figure 2.4 - Changes in total and individual cancer mortality Guernsey females - 3 Year rolling averages 1994-2002

rates per 100,000 resident females



Source: MoH Reports Guernsey 1994-2002

- An additional Health Promotion Assistant has been appointed, who will be involved primarily in cancer prevention. Important areas will be with bowel cancer (the most common new cancer amongst Guernsey males and second most common new cancer amongst Guernsey females), and skin cancers including malignant melanoma where local rates are up to three times as high as those recorded in England.

- The number of chemotherapy clinics held at the Bulstrode House Oncology Unit has increased to three per week (Tuesday, Wednesday and Thursday), although on occasions five day treatments can be given.

- The unit is also participating in five multicentre cancer trials, all of which have been duly approved by the local Research Ethics Committee. A cancer trials nurse has been employed with support from the *Guernsey Society for Cancer Relief.*

- The post of a specialist cancer 'lead nurse' has recently been advertised and an appointment will be made before the end of 2003. The nurse will improve the delivery of local cancer services by providing professional leadership in the provision of expert cancer nursing.

- There has been steady progress in the provision of palliative care services locally. This is now provided both in patients own homes through the district nurses and specialist community palliative care nurses, as well as in more structured settings such as Les Bourgs Hospice and the Cheshire Home.

- In keeping with the NHS *'National Cancer Plan'*, multi disciplinary teams (MDT) have been set up in breast and colorectal cancers, with plans for additional MDT's in lung, gynaecological and pancreatic cancers in due course.

- Guernsey continues to build on its links with the Regional Cancer Services in Southampton. One of the surgeons and the medical oncologist visit Southampton regularly, whilst Guernsey continues to participate and contribute towards the *Central South Coast Cancer Network.*

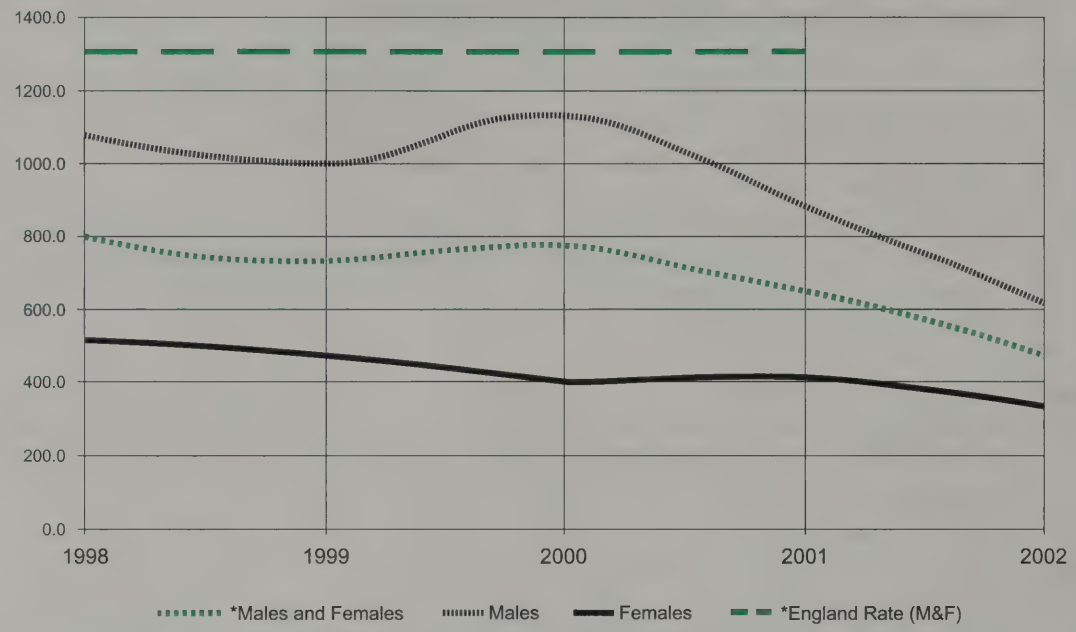
- In the line with the move towards more *'evidence based'* health care, and *'clinical governance'* more generally, there has been increasing interest in the development and implementation of 'integrated care pathways'. The intention is to ensure that only *'evidence based best care'* is given for any particular cancer, and that there is a *'seamless journey'* for the patient across and between services.

Improving cancer outcomes

- There has been a **20%** fall in overall 'all cancer mortality' amongst Guernsey males over the past ten years **1992-2002** *(figure 2.3).*

- There have been even larger falls amongst more common cancers such as lung cancer **(-27%)** and large bowel cancer **(-24%)**.

Figure 2.5 - All cardiovascular disease Under 75's Episode Rate per 100,000 Population



Sources: Hospital Episode Statistics Patient Administration System
Compendium of Health Statistics, Health Economics 2003

Figure 2.6 - AMI and total cardiovascular mortality 3 Year Rolling Averages - Guernsey 1995-2002

Males and Females : rates per 100,000 <75 years

Source: MoH Reports Guernsey 1993-2002

- For Guernsey females over the same period, there has been a **36%** drop in 'all cancer mortality' *(figure 2.4)*.

- There have been particularly dramatic falls in breast cancer mortality **(-51%)** and large bowel cancer mortality **(-39%)**. The smaller fall in female lung cancer mortality **(-14%)** is in part related to the greater number of women who continue to smoke.

Cardiovascular disease

- Cardiovascular disease is the single most common cause of death and the second leading cause of premature death in Guernsey amongst both men and women.

- The *'National Service Framework for coronary heart disease'* was prepared by an independent expert group led by Professor Sir George Alberti, then President of the Royal College of Physicians and was published in **March 2001**. It set out national standards of care for preventing and treating coronary heart disease and described itself as *'our blueprint for tackling heart disease .....'*.

Guernsey NSF cardiovascular disease working group

- Following the model of the *'Guernsey Cancer Strategy'*, a multidisciplinary *NSF cardiovascular disease working group* chaired by the Director of Public Health and comprising senior clinicians, nurses, primary care practitioners and others involved in the management or coronary heart disease met for the first time in **September 2001**.

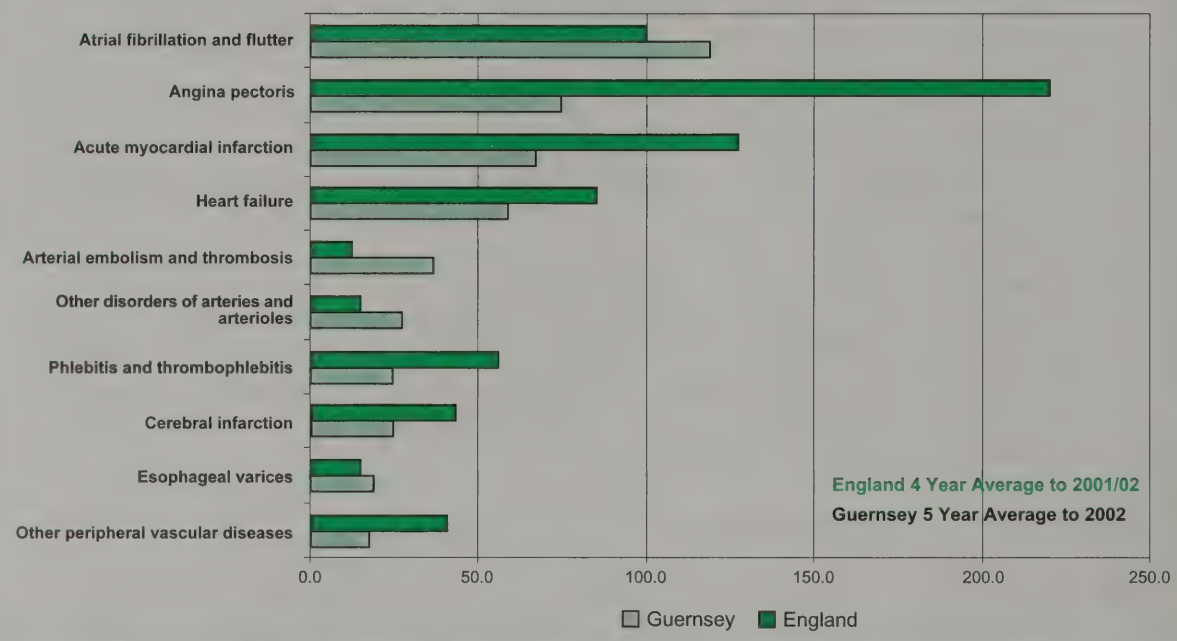
- The group met on eight occasions over the next fifteen months, and systematically compared standards and outcomes of practice in Guernsey with those contained in the NSF. They then proposed a structured list of twenty five recommendations designed to address perceived deficiencies in local services.

- Overall, 'all cause' cardiovascular disease episodes <75 years (as measured by admissions to Board of Health hospitals) are around **50%** lower than figures published from the NHS, and have been falling more rapidly in Guernsey over a number of years *(figure 2.5)*.

- Acute myocardial infarction (AMI) or 'heart attacks' are the main cause of 'premature' (<75 years) cardiac deaths. On three year means, there has now been a **30%** reduction in male AMI deaths from **47.2** between **1993-1995** to **33.2** per 100,000 males population <75 years **2000-2002**. Female AMI mortality has decreased by **17%** from **19.6** to **16.3** per 100,000 females population <75 years during the same period *(figure 2.6)*.

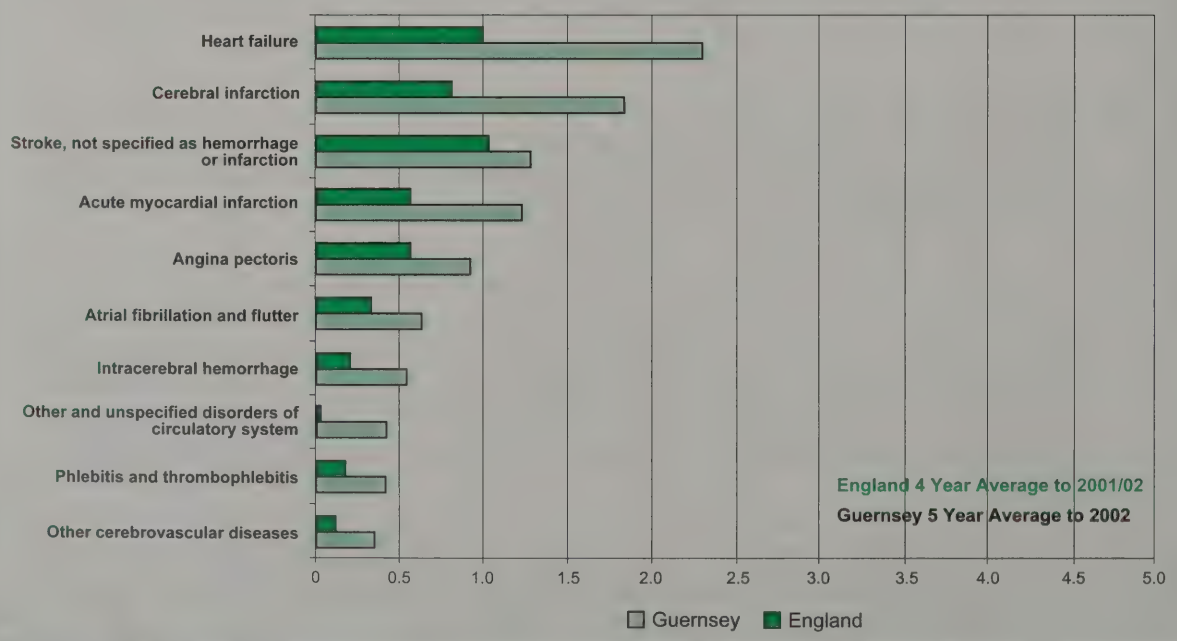
- Overall cardiac mortality <75 years at **95.3** per 100,000 population between **2000-2002** is now **21%** lower than England and Wales, where it was **120.4** per 100,000 population in **2001**.

Figure 2.7 - Top 10 Cardiovascular Disease Episode Rates (Under 75's per 100,000 by Primary Diagnosis) Guernsey v England



Sources: Hospital Episode Statistics Patient Administration System
Compendium of Health Statistics, Health Economics 2003

Figure 2.8 - Top 10 Cardiovascular Disease Bed Days All Ages as % of All Bed Days by Primary Diagnosis Guernsey v England



Sources: Hospital Episode Statistics Patient Administration System
Compendium of Health Statistics, Health Economics 2003

Further developing cardiovascular services

- The findings and twenty five recommendations contained in the *NSF cardiovascular disease report* were accepted by the Board of Health in **June 2003**. These recommendations will be progressively implemented over the next five years or so.

- Generally, Guernsey can be shown to perform well within individual sectors, such as primary care, the St John Ambulance and Rescue Service, the Accident and Emergency Department and coronary care unit at the PEH, subsequent inpatient care and cardiac rehabilitation conducted at the Guernsey Chest and Heart Association premises and in the community.

- However, links between various sectors are often uneven, and a patient with acute cardiac symptoms may not always enjoy a *'seamless patient journey'*. The Report concluded that further improving cardiac mortality in Guernsey must depend on the better 'joining up' of the various components above, aiming for a *'seamless patient journey'* from the earliest prevention of cardiac factors through rehabilitation back into active life for those who have suffered the consequences of an AMI.

- As measured by hospital admissions, our population rates for many cardiac conditions (e.g. angina pectoris, AMI, heart failure) generally appear less than published English figures *(figure 2.7)* although our lengths of stay often appear longer *(figure 2.8)*. The use of more 'integrated care pathways' (ICP) combined with better discharge planning may well improve the *'patient experience'* whilst reducing unnecessary lengths of stay.

- The National Institute for Clinical Excellence (NICE) has recently produced clinical guidelines on *'Management of chronic heart failure in adults in primary and secondary care'*. They point out that with an ageing population and improved care for people surviving heart attacks, heart failure is becoming an *'increasingly common condition with a dramatic effect on the quality of life of people who suffer from it'*.

- Plans are already well advanced to revamp the cardiac unit, and particularly to offer greater availability of echocardiographic investigations - particularly for those with suspected heart failure. The *NSF cardiovascular disease working group* will also be reconvened to examine the NICE guidelines, and further recommend how best to follow these in the Guernsey context.

- Actual clinical practice can then be audited against these national standards, and any proven deficiencies addressed.

- One of the key recommendations of the Report is for the appointment of a cardiac specialist nurse to help co-ordinate cardiac care, implement ICP's and ensure that all those who might benefit from cardiac rehabilitation, (both post AMI and with some forms of cardiac failure) can be properly identified and appropriately referred.

Figure 2.9 - Top 10 Acute Mental Health Bed Days Albecq Ward, Males 1998 - 2002

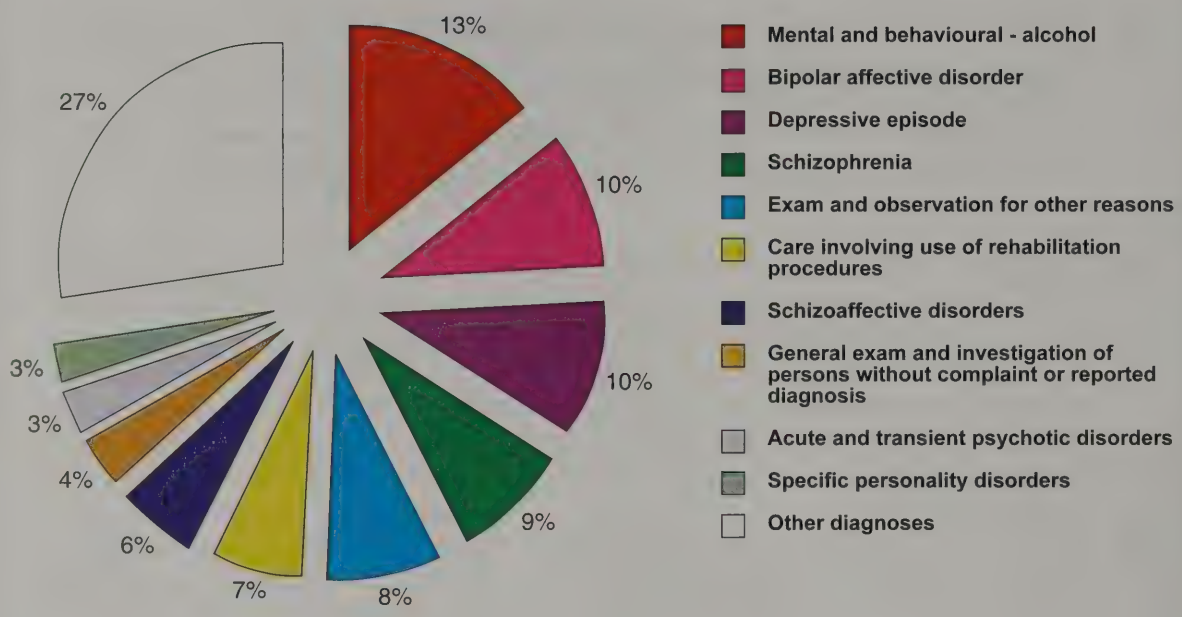
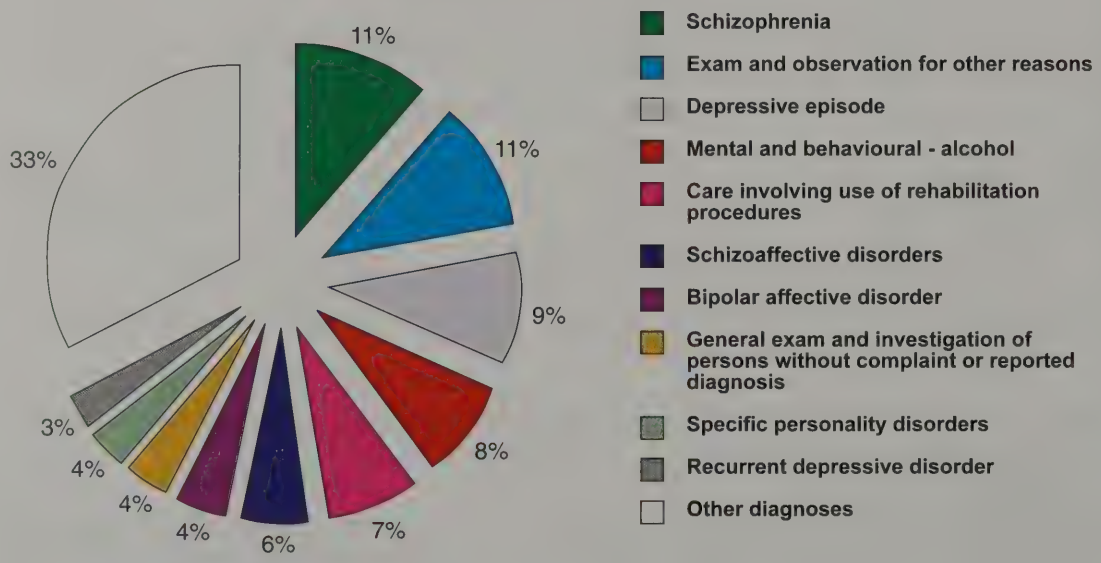


Figure 2.10 - Top 10 Acute Mental Health Bed Days Albecq Ward, Females 1998 - 2002



Source: Castel Hospital Patient Administration System

Mental health services

- A *'National Service Framework for mental health'* exists, and based on this and the recent Health Advisory Service (HAS) reports, a local strategy for mental health is being developed.

- A *mental health steering group* has been formed, and for mush of the year has been involved in planning future services for relocation to the Oberlands site. Facilities on Albecq Ward have long been felt to be unsatisfactory for modern acute mental health care, and the opportunity for new facilities on a new site will lead to better care for mental health patients, and better working conditions for mental health staff.

- Five years data (1998-2002) for both male and female acute admissions to Albecq Ward have now been collated and analysed *(figures 2.7* and *2.8)*. One of the most striking features is the high rate of *'alcohol related mental and behavioural disturbances'* for both sexes which have required aqcute mental admission. It is hoped that the development of community mental health teams and alternative approaches to management may reduce this number in the future.

- The Board of Health accepts that alcohol abuse and its consequences are as much a societal problem as purely a health one. The consequences of alcohol abuse also lead to domestic violence, vandalism, street crime, workplace absenteeism and reduced productivity.

- The Board has therefore been keen to develop a cross committee approach to development of a *'Guernsey Alcohol Strategy'* similar to that which led to the successful *Guernsey Drugs Strategy*. The Board hopes this can now be implemented jointly by the committees with responsibilities in this area.

- Many exciting new service developments have evolved within Mental Health. These include:

  - The early detection Memory Clinic
  - 'relative and carers' groups in both acute and continuing care areas
  - Refurbishment of albecq Ward
  - Ongoing developments in the Day Centre
  - Further development of the Community Mental Health Teams

- There is a commitment to developing the 'clinical governance' agenda, examples of which include:

  - The local clinical audit group, which has undertaken an audit of *'key workers'* and *'non attendance'* at outpatient clinics.

  - The launch of a multidisciplinary academic session within Mental Health Services.

Figure 2.11 - Care of Older People 75+ Staying in Hospital <91 days, Top 10 Primary Diagnoses (Bed days) Males 1998 - 2002

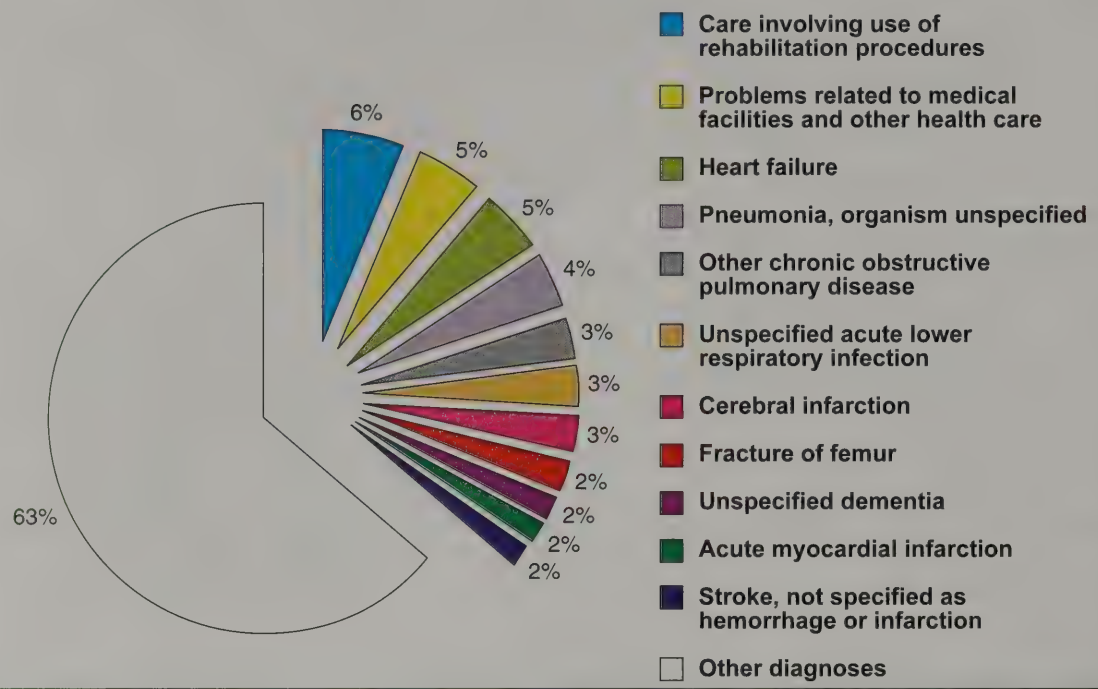
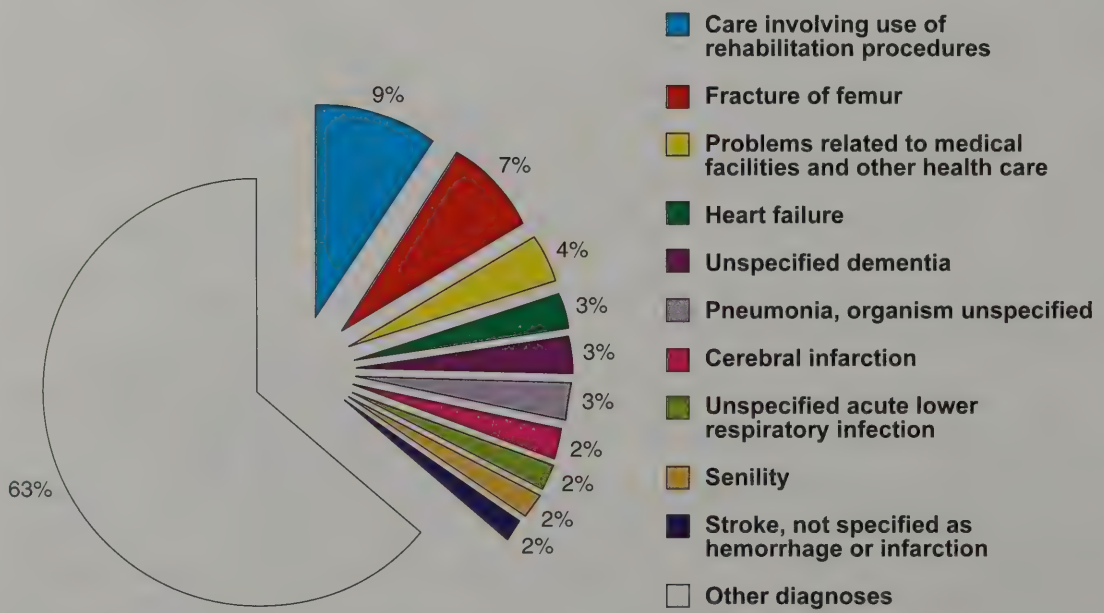


Figure 2.12 - Care of Older People 75+ Staying in Hospital <91 days, Top 10 Primary Diagnoses (Bed days) Females 1998 - 2002



Source: Patient Administration System - All Hospitals

- Along with those exciting service developments, the following new posts have been created:

  - A senior nurse for the Community Mental Health Team
  - A Clinical Nurse Specialist in Substance Misuse (drugs)
  - A further Clinical Nurse Specialist post for older people with mental health problems
  - Feeding and nutritional assistants on the continuing care wards
  - Further development of the activities services at the Castel Hospital

- Locally service user involvement is beginning to develop. The Day Centre and Albecq Ward have service user groups and there are both relative and carer groups within the acute and continuing care settings.

Services for Older People

- According to the 2001 Census, there are **9,366** persons >65 years resident in Guernsey, comprising **15.7%** of the population. Analysis of acute inpatient admissions (defined as all planned admissions <91 days) shows that this group occupy **57%** of acute bed days across all Board of Health hospitals.

- However, those >75 years (**4,434** persons, **1,630** males, **2,804** females) comprise only **7.4%** of the population, but occupy **40%** of acute bed days, i.e. those aged 65-75 years do not show greatly increased need for hospitalisation compared with the adult population of Guernsey as a whole. However, *'need for admission'* and average *'length of stay'* appear to increase sharply amongst those over 75 years.

In previous analyses of acute hospital admissions for those >75 years a few 'long stayers' have distorted the overall position. In many cases, their lengthy admissions appear to have been more due to lack of alternative homecare provision, rather than to their medical needs. All admissions over 90 days have therefore been excluded as cases of 'delayed discharge' although this is obviously not true in all cases. On this basis, between the years **1998-2002**.

- Amongst Guernsey males, commonest reasons for the admission are *heart failure* (**5%**), *pneumonia and chronic obstructive pulmonary disease* (**8%**), *cerebral infarction and stroke* (**5%**) and *fracture of the femur* and *acute myocardial infarction* (both **2%**) *(figure 2.9)*.

- Amongst Guernsey females, the leading uses of bed days include *fracture of the femur* (**7%**), *respiratory infection* (**5%**), *cerebral infarction and stroke* (**5%**) and *heart failure* (**3%**) *(figure 2.10)*.

It should be noted that in common with coding practice in the UK, admissions for 'rehabilitation' will in future be coded to their underlying cause. This means that the proportion of admissions due to fracture neck of femur, cardiac failure and stroke are likely to show further increases in future years.

National Service Framework for Older People

- This was published in **March 2001**. It proposed a series of approaches to ensure high and consistent quality of health care for the elderly across Britain.

- Key approaches highlighted in the *'National Service Framework for Older People'* include:

    - *Minimising 'age discrimination', and the provision of 'person centred care*
    - *Development of more facilities for 'intermediate care' services*
    - *Specialist elderly care services in hospitals*
    - *Better prevention, investigation and management of stroke*
    - *Prevention of falls and the reduction of resultant fractures*
    - *Medication reviews to reduce 'excessive, inappropriate or inadequate medication'*
    - *Promotion of health and well being in older people*
    - *Access to integrated mental health services*

In Guernsey, the *'Health care for older people'* strategy will be guided by the same principles:

- Older people will be encouraged and facilitated to remain in their own home for as long as possible. The Board will be allocating extra resources to community teams to support this.

- There are many older people who, although finding their own home too large and difficult to manage, do not merit admission to a residential or nursing home. States housing policy now favours the priority development of *'sheltered housing'* or *'warden assisted'* flats to assist this group. Proposed developments include Rosaire Avenue, St Peter Port, (85 units - 50 for affordable rental, 9 for sale on affordable lifetime leases and 26 for sale at market value) and Bulwer Avenue (17 units).

- For the minority who do require higher levels of care, admission to residential and nursing homes will be following satisfactory assessment from the Needs Assessment Panel. The States accepted the Guernsey Social Security Authority's *'Long-term Care Insurance'* in **April 2002**. This means that, in return for a graduated premium and a co-payment, Guernsey residents will be able to access such care without the need to sell the family home or dispose of other hard accumulated assets.

- With regard to hospitalisation, the Board will be focusing on reducing admissions and speeding discharge.

- Since *'fracture neck of femur'* is the most common cause use of bed days in women >75 years, and the sixth most common use of bed days in men of the same age, the Board has adopted a *'Guernsey Osteoporosis Strategy'* aimed at identifying those at most risk of osteoporosis and ensuring that they receive treatment that will retard or reverse the development of osteoporosis.

- A specialist osteoporosis nurse has been employed to co-ordinate this programme, and it is hoped that DEXA (a specialist imaging technique) to detect loss of bone mineral density will be available in Guernsey in the near future.

- Similarly with *'heart failure'*, - which is responsible for **5%** of acute bed days in older Guernsey males and **3%** in older Guernsey females. As summarised under cardiovascular disease above, NICE guidelines suggest that more active management of heart failure, especially in older people, would help improve health outcomes.

- Action should also be taken to prevent strokes and people who are thought to have had a stroke should have access to diagnostic services, be treated appropriately by a specialist service and be able to take part in a health programme of rehabilitation and avoidance of subsequent strokes.

- The development of a specialised stroke service for people of all ages is linked to the Board's strategy for the care of older people with, again, specialised facilities and increased staffing numbers in the rehabilitative services, such as speech and language therapy, occupational therapy, specialist and community nursing.

- These new developments will shift the emphasis of medical and nursing care towards assessment and rehabilitation of patients whilst recognising the need for the Board to continue to provide a level of nursing care for those patients who cannot be cared for within the private residential or nursing home sector, principally because of the severity of their illness.

- To meet these needs and to help reduce age discrimination, the Board sees the need to remove the existing distinction between its adult medical services and those provided for its elderly population. A first step has been taken by including within the contract with the Medical Specialist Group general physicians who have an interest in older people, but who also care for adults generally whatever their age. Physicians employed by the Medical Specialist Group now have specialist interests in cardiology, respiratory, renal, cancer, strokes and falls, which they will provide to the population regardless of age.

Children's Services

- According to the 2001 Census, there were **10,300** children 0-14 years resident in Guernsey, equivalent to **17.2%** of the resident population.

- However, births have fallen from over **700** in **1992** (a crude birth rate of 12 per 1,000 population) to less than **550** in **2002** (a crude birth rate of 9.2 per 1,000 population) - this represents a fall of **24%** in ten years. In **2002**, for the first time since the Occupation years, deaths exceeded births in Guernsey i.e. the island had a negative *'natural increase'*.

- For socio-economic and other reasons, Guernsey's birth rate is likely to continue to fall. As the proportion of the elderly population rises, the relative proportion of the child population will continue decrease.

- The reason why children contact health services is also changing. Admission for physical illness is likely to become less common, and to be for shorter lengths of stay. At the same time, contact for mental and psychosocial problems (autism, attention deficit hyperactivity disorder, psychosocial problems related to family breakdown and divorce, drug experimentation, etc) are likely to continue to increase.

- The NHS has published the first part of a *'National Service Framework for Children'* focusing on the care of children in hospital. 'Children's services' are being widely interpreted in the context of the *'National Service Framework'*, and will include maternal and perinatal service. Second and subsequent components of the *'National Service Framework'* will focus on services required for children in the community.

- Additionally, it has been announced that under the *'Machinery of Government'* reforms, there will be a merger between the Board of Health, the Children Board, and long term residential care currently administered by the Guernsey Housing Authority together with St Julian's Hostel into a new *'Department of Health and Social Services'*.

- Deciding on the structure and range of services to meet these changing trends and benchmarking these against the standards in the *'National Service Framework'* will be essential to ensure the best and most appropriate range of services for children and young people in Guernsey. This will be further advanced in the coming months.

Services for with a learning disability

- A Planning Advisory Co-ordinating Team (PACT) has been established to continue to develop Services for People with a Learning Disability. This is unusual in that it has representation from both services users and their carers actively involved in the planning process. PACT has already met on several occasions.

- Unfortunately, missing data has meant that a full analysis of the healthcare needs amongst the learning disabled could not be completed in time for this Report. It is difficult to ensure an adequate and appropriate allocation of resources for future developments without sufficient factual basis. It is hoped to address this over the next several months and to publish the results in next year's Report.

The Director of Public Health wishes to acknowledge assistance received from Consultant Oncologist, Dr Peter Gomes, Deputy Director of Health Studies and Nursing Services, Mrs Sue Fleming and the Director of Health Care Services, Mr Keith Sirett for their help in preparing the 'cancer', 'mental health', and 'care of older people' sections. Although every effort has been made to ensure the accuracy of quantitative data contained in this chapter, low annual numbers and wide year to year variation means that there must be wide 'confidence intervals' around many of the values given, and they should be interpreted with this proviso.

Chapter Three

Environmental Health 2002

Overview

2002 was the first year for a while that the department had a settled staff. Marilyn Bougourd returned to the department as office secretary after an absence of more than 3 years. The professional staff of the department remained unchanged for the whole year and this enabled progress to be made towards compliance with the LACORS (Local Authorities Coordinating Office on Regulatory Services) standard for risk assessment and inspection of food premises, as well as implementing new initiatives of which more below.

The department continued to work towards implementation of the States' Solid Waste Strategy. The Board of Health has agreed that the *'Control of pollution'* functions of the Environmental Health Department will become independent and a new independent appointment will be created to replace the Chief Environmental Health Officer in this role. This will become a reality when the *Control of Environmental Pollution (Guernsey) Law*, which is finally nearing its completed form, is enacted, probably later in 2003. Delay in the enactment of this Law still continues to hamper the effective protection of the Guernsey environment.

For the first time the department organised a local heat of the National Curry Chef Competition. This nationwide competition has been running since 1992 and as well as giving local curry chefs the chance to show off their culinary excellence, promotes high standards of food safety and hygiene in the workplace. Eight chefs from various local restaurants entered the competition organised jointly with the College of Further Education. A hygiene assessment was made of all the competitors' premises prior to entry and most undertook and passed the CIEH Foundation Food Hygiene Course, thereby raising hygiene standards. The winner of the local heat also won the South West regional heat held in Swindon to secure a place in the National Final, held in Harrogate in September 2002.

During the year, the department introduced an innovative training initiative for new workers in the food industry. Basic training courses on CD Roms were purchased by a number of local businesses to enable them to train their own staff in-house. The computer based learning enabled candidates to proceed at their own pace and to spend longer over problem areas or items that were of relevance to their jobs. A certificate was available for those candidates who successfully completed the various elements of the course. CD's were available in both English and Portuguese, enabling a larger number of participants. 75 places were sold in 2002 and we hope that this initiative, with other languages becoming available, will continue.

Figure 3.1 Food Safety and Infection Control

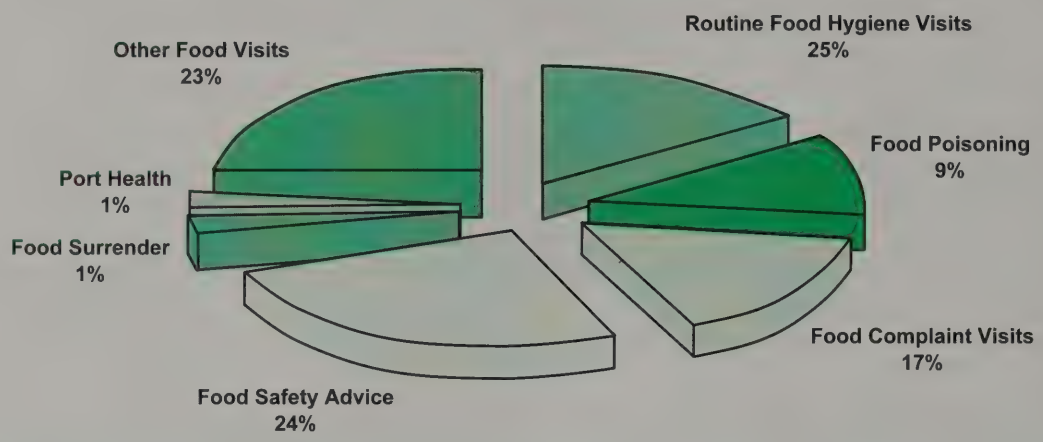
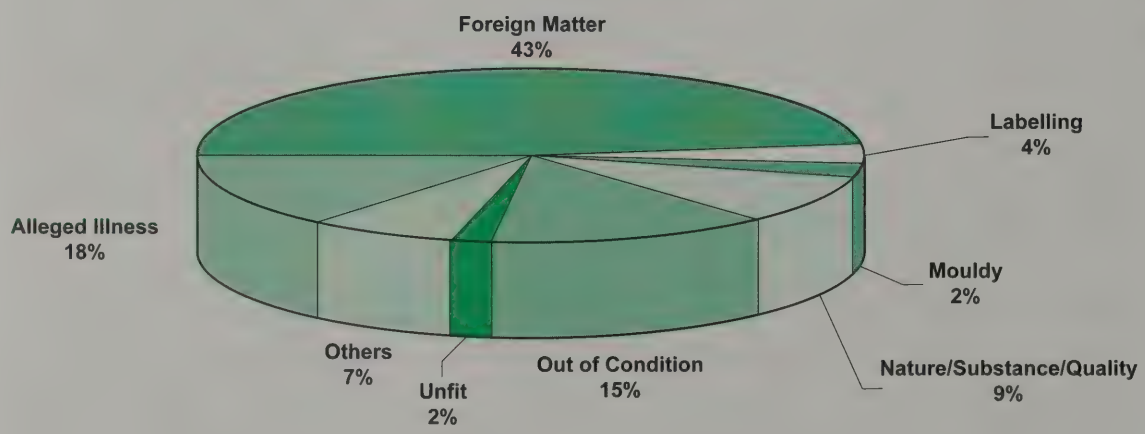


Figure 3.2 Food Complaints 2002 - 54 Complaints



Visits by Department Staff

Six professionally qualified Environmental Health Officers are employed by the department - Chief Environmental Health Officer John Cook, Deputy Chief Environmental Health Officer Tony Rowe and Environmental Health Officers Stuart Wiltshire, Stan Horton, Tobin Cook and Mhairi Macgregor. Officers work in two main sections - **Food Safety and Infection Control**, which deals with all aspects of food control, including the inspection of food premises, dealing with complaints about food, promotion and undertaking of food hygiene training and the investigation of the causes of infectious and food-borne disease, and Environmental Control, which deals with all matters affecting the environment, including housing, noise and air pollution. Routine measurements of environmental parameters, including air quality and seawater, are also undertaken. Waste regulation now forms an integral part of the section and the department employs a professionally qualified Waste Regulation Officer, Simon Welch. The department also deals with rodent control and employs two rodent control operatives, Paul Tostevin and Michael Brache. The department carried out a total of **6,731** visits during **2002** and these are detailed under the section headings.

Food safety and infection control (Figure 3.1)

The department continued to promote its Hygiene Award Scheme in 2002, following its successful launch in 1998. The Award scheme recognises high standards in food hygiene and is divided into three parts - practice and structure, hazard analysis and staff training. In each area emphasis is placed on complying with the legal requirements, recognising good practice and the demonstration of due diligence. Eight awards were made in 2002, one down on the previous year but the improvement made over 2000, when only three awards were made, was maintained.

The Food Safety section made **2,014** visits during the year 2002. Of these **1,054** were initial visits, with **960** being revisits.

Food complaints (Figure 3.2)

A total of **54** food complaints were received during the year, a decrease over the **69** recorded in 2001 and the **72** in 2000.

In **28** cases, the complaints were either unsubstantiated or the source of the problem occurred subsequent to the purchase of the food. None of the complaints was referred for prosecution.

Food Surrender

Only **8** food surrender certificates were issued during the year. This compares to **30** issued in 2001 and **27** in 2000. The Board's policy of charging for the issue of certificates, freeing valuable officer resources, continues to keep such requests to a minimum and there has been a great reduction from the peak of over **200** in **1992**.

Figure 3.3 Basic Food Hygiene Certificate Training

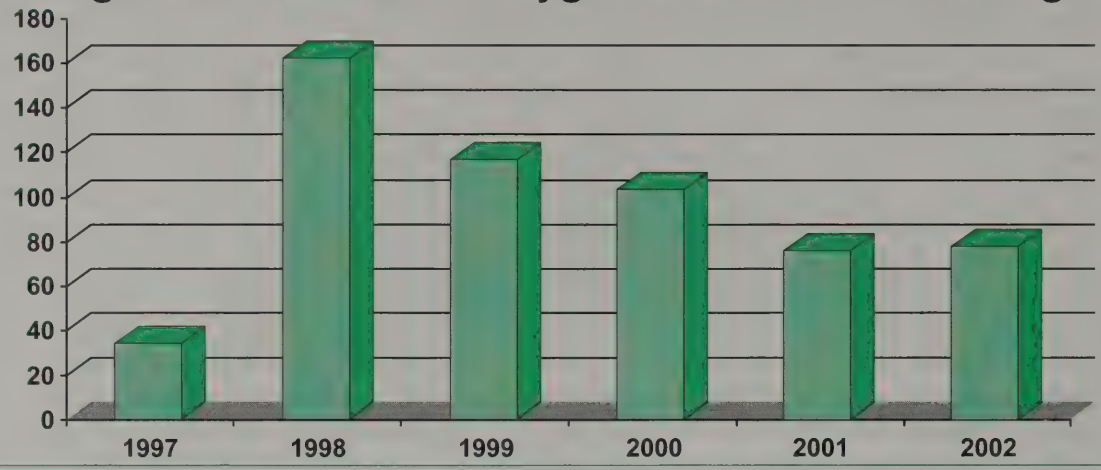


Figure 3.4 Salmonella/Campylobacter Notifications 1996 - 2002

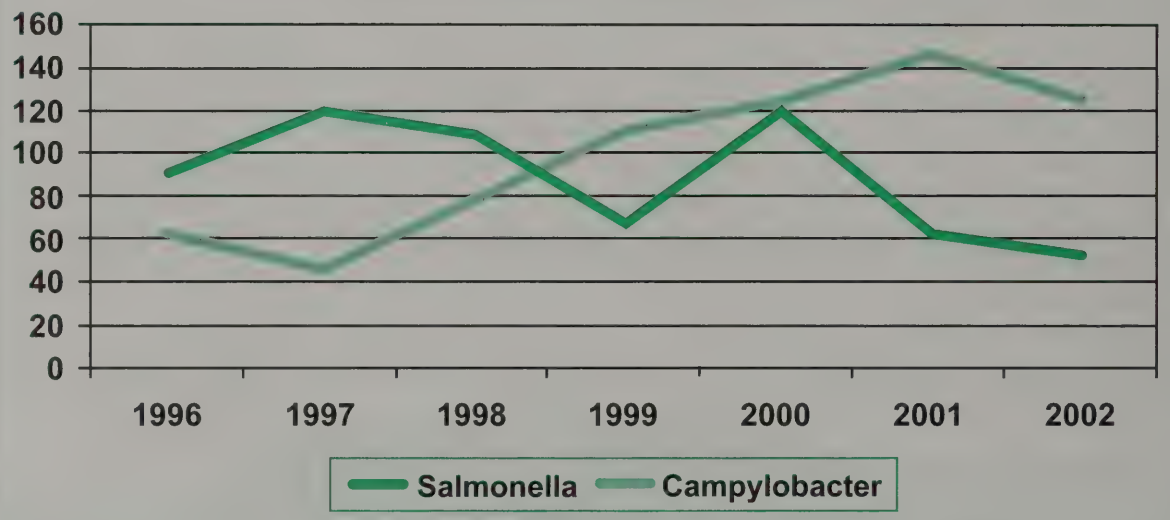
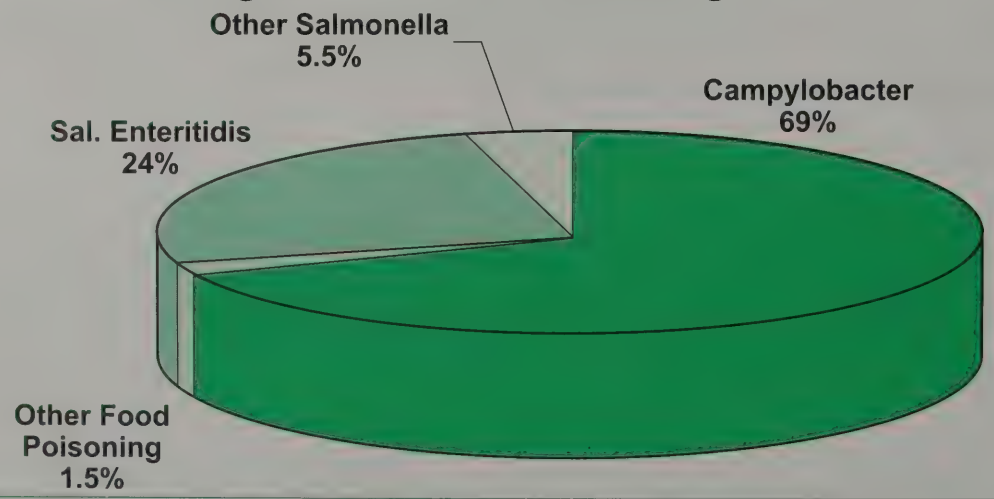


Figure 3.5 Food Poisoning 2002



Food Hygiene Training (Figure 3.3)

The Board's Hygiene Award Scheme has continued to generate interest in the Chartered Institute of Environmental Health's Foundation (previously Basic) Food Hygiene Certificate.

A total of **9** Foundation Food Hygiene courses were run by the department in 2002. Of the **78** candidates, **77** successfully completed the course and were awarded the Certificate. One Intermediate Food Hygiene Course was run during the year with **6** candidates, **5** of whom successfully passed the examination.

Formal action

It only proved necessary to serve **4** Improvement Notices during the year. This compares to **16** Notices served during 2001. **2** premises were involved - a hotel was the subject of three Notices concerning lack of cleaning and an associated infestation, damaged flooring and lack of personal washing facilities, whilst one restaurant was served a Notice for damaged floor finishes and consequent lack of proper cleaning. All improvement notices were complied with. A prosecution for food hygiene offences held over from 2001 was dealt with by a caution. There were no prosecutions during 2002.

Food poisoning (Figures 3.4 and 3.5)

A total of **51** confirmed cases of salmonella food poisoning were notified to the department during 2002. This figure is again a reduction on the previous year's figure of **62** and follows the dramatic reduction seen between 2000 and 2001. This is the lowest number of cases seen in the last ten years and confirms the downward trend seen over recent years. All were individual cases or family outbreaks and **11** originated outside the Bailiwick. Raw or undercooked eggs were the foods most commonly indicated as the vehicle of infection. There were **3** cases of food poisoning caused by other infectious agents but no cases of E. coli 0157 were notified. Additionally, there were **123** confirmed cases of Campylobacter, a considerable reduction on the **147** cases notified in 2001. However, this only slightly offsets the upward trend of Campylobacter notifications of recent years.

Environmental control (Figure 3.6)

Officers made a total of **2,296** visits during 2002. **1,102** were initial visits with the remainder (**1,194**) being follow up visits.

Figure 3.6 - Environmental Control

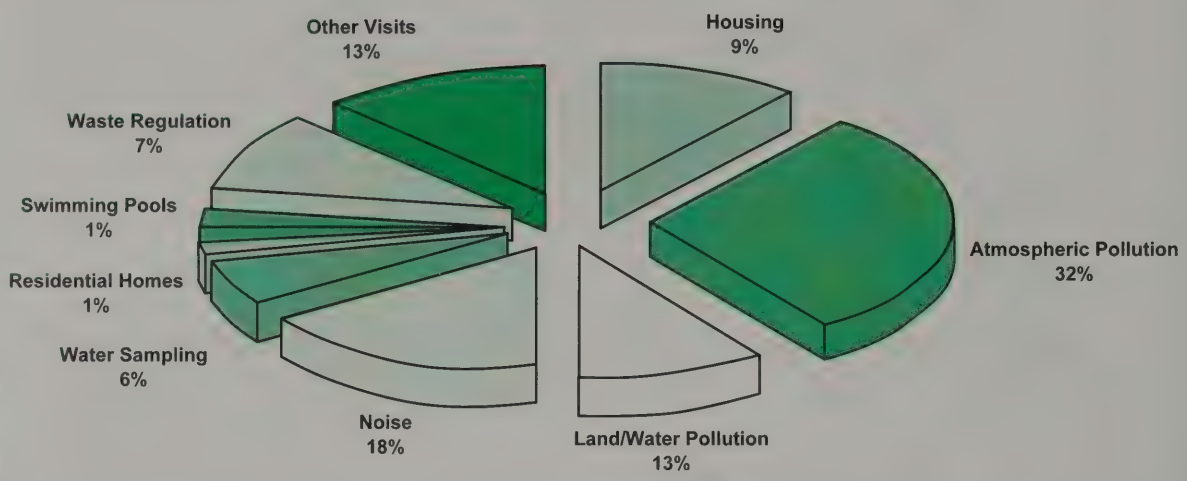
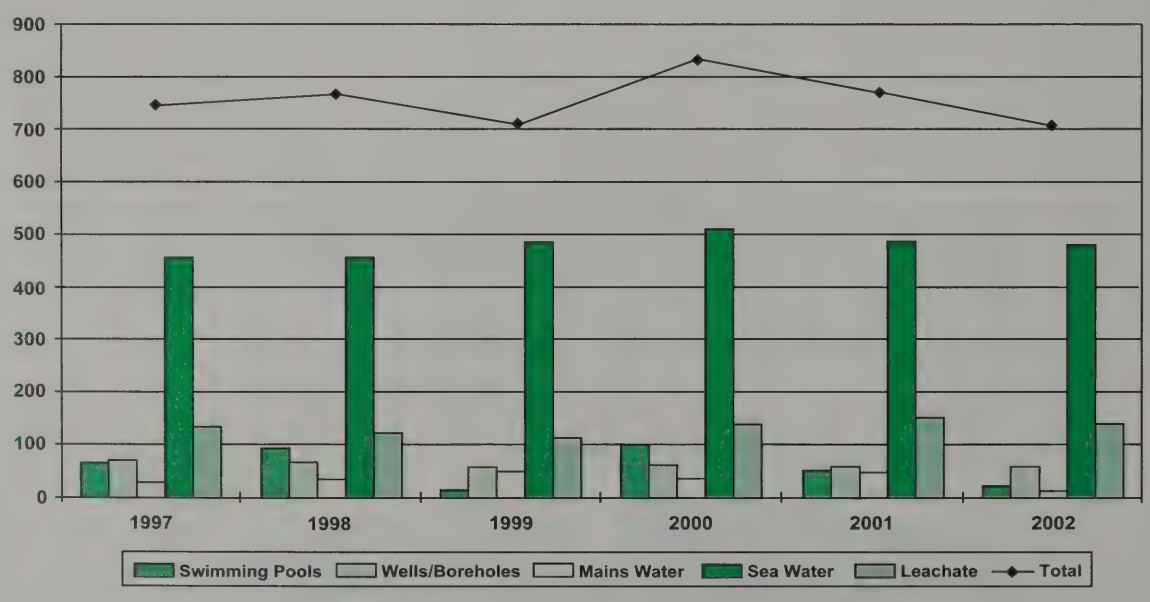


Figure 3.7 - Water Samples 1997-2002



Water Samples (Figure 3.7)

The following samples were taken during 2002 for chemical and/or bacteriological analysis.

Water Samples 2002	
Swimming Pools	19
Wells	21
Boreholes	34
Mains Water	12
Sea Water	476
Leachate	142
Other Water Sources	0
Totals	**704**

Figure 3.7 compares the 2002 sampling programme with previous years' sampling.

Rodent and Pest Control

1,403 treatments were carried out including **62** disinfestations. Systematic treatments of bays and headlands have continued throughout 2002. Rodent control operatives carried out **2,421** visits in total during the year.

Housing

66 complaints were received during 2002. This resulted in **227** visits to premises to assess housing conditions and to ensure unsatisfactory conditions were remedied. Areas of concern included overcrowding, dampness and unsatisfactory living conditions. The vast majority of the complaints were dealt with by informal action with landlords but it proved necessary to issue five closing notices in respect of units of accommodation *'unfit for human habitation'*. Two of these units were single rooms with associated facilities, one was the wing of a larger house and the other two were whole houses.

Air Quality (Figures 3.8 - 3.9)

The department's real time air quality monitoring continued throughout 2002. Results indicate that the general air quality of Guernsey remains very good. No exceedances of the relevant guidelines were noted and average levels of the measured pollutants were considerably below the guideline levels.

Nitrogen Dioxide (Roadside)			
Standard	Level in ppb	Maximum Concentration	Date
WHO Health Guideline (1 Hour)	210	66	5 April
WHO Health Guideline (24 Hour)	80	22	26 March

WHO = World Health Organisation

Figure 3.8 - Nitrogen Dioxide Survey - Results in parts per billion (ppb) in St. Peter Port 1997 - 2002

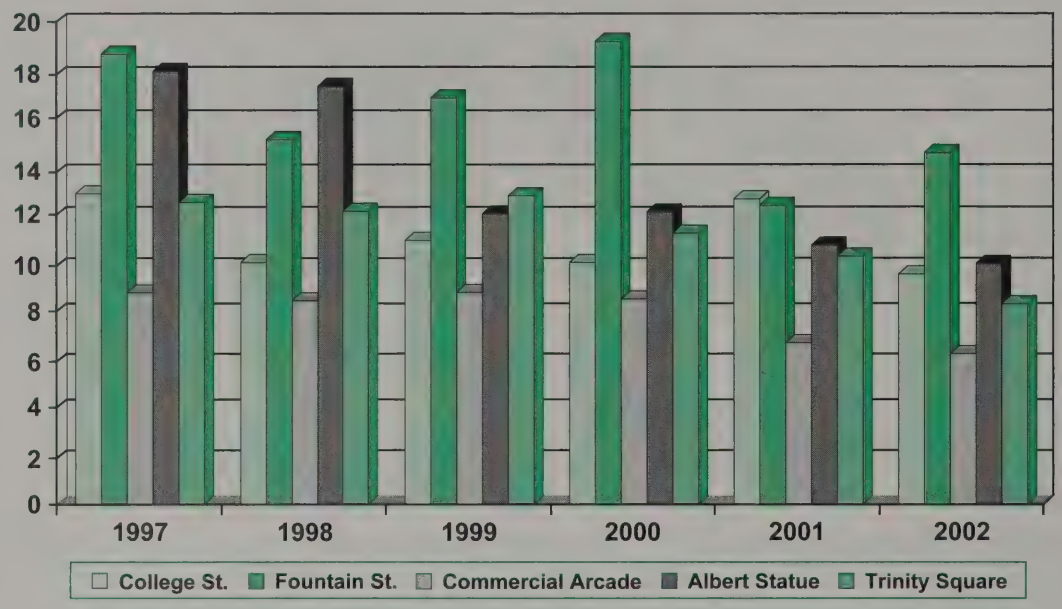
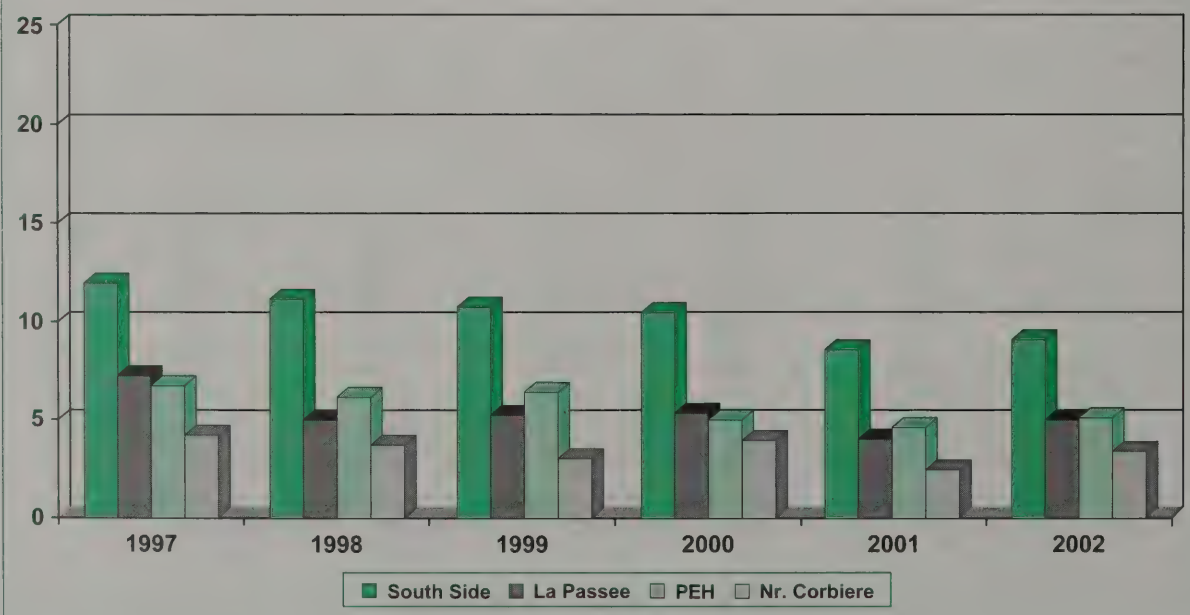


Figure 3.9 - Nitrogen Dioxide Survey - Results in parts per billion (ppb) at other island sites 1997 - 2002



Nitrogen Dioxide (Background)			
Standard	Level in ppb	Maximum Concentration	Date
WHO Health Guideline (1 Hour)	210	41	18 November
WHO Health Guideline (24 Hour)	80	18	17 February

Sulphur Dioxide			
Standard	Level in ppb	Maximum Concentration	Date
WHO Health Guideline (1 Hour)	122	27	17 February
WHO Health Guideline (24 Hour)	100	9	17 February

EPAQS = Expert Panel on Air Quality Standards

Particulates (PM 10)			
Standard	Level in ppb	Maximum Concentration	Date
WHO Health Guideline (24 Hour)	70	50	17 February

The department also continued its monthly nitrogen dioxide survey at nine sites around the island. The downward trend of previous years continued, with levels in College Street being reduced to lower than that recorded in 2000 and other roadside sites showing reductions. Levels in Fountain Street showed an increase but both Fountain Street and the Bordage were closed for significant periods during 2001 and this had an obvious effect on measured levels during that year. Background levels (measured at three of the sites) showed a slight increase over previous years.

The UK's Department of the Environment indicates that levels of nitrogen dioxide below 50 ppb indicate "Very Good" air quality. The results show that, in spite of annual increases in the number of registered vehicles, the standard of air quality in respect of nitrogen dioxide continues to rise and is well within recognised international standards.

Formal action

Two *Abatement of Nuisance* notices were served during the year.

The first was on the States of Alderney and concerned the nuisance arising from the burning of the island's refuse at the States Impôt. This practice had been undertaken for many years and had given rise to numerous complaints during that time. With the change in the public health law that occurred in 1999, the department were at last able to formally address the nuisance caused. A draft waste strategy for Alderney was produced in 2000 and this was independently assessed in 2001. However, practices at the Impôt remained unchanged. Following numerous complaints in the first part of 2002 and being advised that the waste strategy, including the provision of an incinerator, would take 12 - 15 months to implement, an Abatement of Nuisance Notice was served in May 2002 requiring that burning causing nuisance be stopped at the Impôt within 3 months. This period was set to allow an interim solution, involving the export of waste to Guernsey, to be implemented. The States of Alderney have ceased to burn when conditions

would cause a nuisance but continue to burn at other times. The interim solution has not been implemented and at the end of 2002 the contract for the incinerator had yet to be signed.

The second was on a restaurant that caused smell nuisance to neighbouring properties from its ventilation system. Court action had been deferred to allow work to improve the system but this had not been completed at the end of the year and the Notice remained outstanding.

Two particular types of nuisance have been significant to the department during the last year. Once again I have to bemoan the fact that bonfires of all types continue to be a major cause of complaint to the department. A considerable amount of staff time is used dealing with complaints that could, with more consideration, be avoided. There are a number of alternatives to the burning of waste material and most complaints arise through thoughtlessness and a lack of awareness. Although overall air quality continues to improve, indiscriminate burning of unsuitable materials gives rise to very considerable local nuisance. Education and the exercise of consideration for neighbours are necessary to reduce nuisance from this generally unsuitable practice, since formal action under the public health laws is only suitable for the major polluting incidents.

The incidence of noise complaints has also continued to rise. Of particular concern to the department is the increase in complaints about noise from building sites working at unsuitable hours, that is early morning, late evening and even at night. Working on sites on Sundays is also on the increase and this may be due to the rise in the employment of non-local labour. Residents in the neighbourhood of major development sites have a reasonable expectation of some respite from the inconvience necessarily involved with major projects. This area of noise control is one of the areas that will be addressed when the Control of Enviromental Pollution (Guernsey) Law is enacted during 2003.

John Cook
Chief Environmental Health Officer

Chapter Four

Health Promotion Unit - 2002

Introduction

The last twelve months have been as busy as ever with both ongoing projects and the start of brand new programmes. The Resources Officer continued to support a large number of clients and from June 2002 to June 2003 issued 87,443 leaflets and posters (a shortfall from the previous year) and 1,975 resources (a slight increase) including books, videos, teaching packs and models. She also put up displays at numerous venues around the island to increase awareness of the campaigns put on by the Unit. Over Easter a thorough stock check was made of the whole resources library enabling easier access to the materials and highlighting areas for future purchases.

Cancer prevention

The Unit gained a new member of staff in January when Lucy Whitman became the Health Promotion Assistant for cancer prevention. Her appointment was as a result of the Board's Cancer Strategy and a proportion of her time has been spent in planning work in line with both the local strategy and the NHS cancer plan.

Activities undertaken in this area have included three more cancer prevention in-service training days for teachers, a half-day training for Live for Life tutors and production of a training manual to enable tutors to lead cancer prevention workshops for the public. Work with staff from GASP has also taken place to enable them to include cancer prevention when talking about the benefits of stopping smoking.

Several specific cancers have been highlighted, in particular bowel cancer in April and skin cancer in May and June. The Health Promotion Assistant produced a new sun ultra violet index card and visited every pharmacy and community chemist to encourage them to promote sun awareness. She also worked closely with the local organisers of the *Race for Life* to encourage women to take up exercise and recognise that cancer is both preventable and treatable. This was followed by a series of free physical activity taster sessions, open to the public, which included sailing, yoga and dancing.

The Health Promotion Assistant also wrote a variety of newsletter articles on cancer prevention topics and produced a new cervical smear leaflet that is being used in all the surgeries. Future projects include programmes on specific men's and women's cancers and prevention in workplaces.

Healthy schools

The National Healthy School Standard scheme continued to expand and was supported by the Health Promotion Manager and Primary PSHE Co-Ordinator. A new protocol to implement the scheme was designed and accepted by the Education Council and two schools, Vale Infant and St Martin's Primary, were presented with their awards at a ceremony in June.

Three more schools are working towards the Standard following a training day organised by the Hampshire Healthy Schools Partnership.

The Health Promotion Unit also worked in partnership with the Education Council to fund the third *'Schools Heatlh Related Behaviour Questionnaire'*, which surveyed all the islands' children in Years 6, 8 and 10. The results were published in May and they are now being analysed to assess the implications for future practice. A full time PSHE Consultant was finally appointed to start work in September 2003. This post will enable further developments in all areas, but particularly Secondary schools as well as links with the new Citizenship curriculum.

Child accidents

The Child Accident Prevention Group, chaired by the Health Promotion Manager, undertook a variety of activities and she represented them on the *'Vulnerable Road Users Working Party'* and *'Fireworks Safety Committee'*. The annual *'Safety Calling'* event for Year 6 pupils was cancelled due to the Island Games but instead, members of the group travelled to Alderney to set up a version for St Anne's School over there. This will mean the school will be able to run its own initiative for all pupils rather than having to choose six children to send to Guernsey.

The annual attendance figures for children under 15 attending the Accident and Emergency Department at the Princess Elizabeth Hospital were analysed by the Healthcare Information Unit and showed a 9% drop over 6 years. This still means that over twelve months nearly 2,000 children received injuries due to accidents but the staff of a downward trend was very pleasing.

Smoking

Smoking is still the greatest cause of death and disease on the island and so it continued to be the Unit's major priority. The Health Promotion Officer (smoking and heart disease) worked closely with GASP - now called the Guernsey Adolescent Smokefree Project, on a number of activities including training six young people at St Peter Port School to deliver smoking education to younger pupils. The Sports Development Officers also took part, offering alternatives to smoking, particularly football for girls. The Health Promotion Officer was also involved in the recruitment and training of a GASP Detached Youth Worker to work with 14 to 18 year olds.

Guernsey *'Quitline'* continued to work well with smokers who wanted to stop and have now started to offer eight weeks free nicotine replacement therapy instead of one month and this has proved to be very favourable. A further development in the autumn will be the ability for advisors to offer a combination of several therapies that should increase success rates even more. In the light of the professional service now delivered by *'Quitline'* staff a Service Level Agreement was drawn up between Quitline and the Health Promotion Unit, outlining the quality of service to be provided.

The Health Promotion Officer for smoking also organised a variety of events for No Smoking Day, sent out over 15,000 information packs and ran smoking cessation training days for health professionals.

A new project has also been the employment of a Tobacco Rescarch Officer to monitor the sales of tobacco to under 18s. His presence has already had an effect and he hopes to visit more premises during the coming months.

Alcohol and drugs

The Health Promotion Manager continued to attend the *'Drug Strategy Action Group'* and was involved in the *'Drugs Awareness Week'*. She also attended the Alcohol Strategy Group meetings and participated in the recruitment of the Alcohol Education Worker for GADAC.

Heart disease

The Health Promotion Officer (smoking and heart disease) worked with the *'Cardiac Action Group'* to increase the support available to cardiac rehabilitation patients, including a rolling programme of courses and CPR classes. A database of all clients has been set up and she gave two presentations to professionals to increase awareness of the services available.

Both the Health Promotion Officer and Health Promotion Manager were heavily involved in assessing the new Live for Life tutors as they worked through their NVQ Level 3 in training and all should have completed the award by the end of September. The tutors have been kept very busy running a series of healthy lifestyle sessions for the general public, workplaces, College of Further Education students and at Charity events. Topics covered included healthy eating, stress and weight control, and it is hoped to increase the number of sessions available once all the tutors have qualified. A Healthy Hearts month is also planned for September which is aimed at increasing the general public's knowledge and understanding of heart disease prevention.

Health promotion

Several sessions were conducted on the theory of health promotion for visiting groups and preparations were made for conducting the fourth *'Guernsey Healthy Lifestyles'* survey in November. The Health Promotion Assistant has been accepted onto the Diploma in Health Promoting Practice Course in October and the Health Promotion Officer (smoking and heart disease) is working towards NVQ Level 4 in Management.

Conclusion

In addition to the areas already mentioned, the results of the *'Healthy Lifestyles'* survey will dictate the future direction of the work of the Unit. There is also a continuing trend towards evidence-based practice in health promotion and the number of UK reports and briefings on a variety of topics are increasing. These will all be analysed to ensure that the Health Promotion Unit's work is as up to date, relevant and efficient as possible in the next 12 months.

Yvonne Le Page
Health Promotion Manager

Table 5.1
Notification of Communicable Diseases 2002

	1997	*1998*	*1999*	*2000*	*2001*	*2002*
Measles	0	0	0	0	0	**0**
Mumps	0	0	0	1	0	**0**
Rubella	0	0	0	1	0	**0**
Whooping Cough	0	0	1	5	0	**3**
Food Poisoning	171	189	237	246	217	**167**
Hepatitis A	2	0	0	3	3	**0**
Hepatitis B	2	3	1	2	0	**0**
Hepatitis C	0	2	0	1	0	**3**
Meningitis	3	4	0	11	1	**1**
Tuberculosis	0	3	6	2	5	**2**
Malaria	0	0	0	0	0	**1**
Scarlet Fever	0	0	1	0	0	**0**
Psittacosis	0	0	0	0	0	**0**
Dysentery	0	0	0	0	0	**0**
Q Fever	2	1	1	0	0	**0**
Legionella	0	0	0	0	0	**2**

Chapter Five

Communicable Disease and Sexual Health

Infectious diseases 2002

Food poisoning continued to be by far the commonest notified infectious disease with 167 cases. There would have been many other cases that did not lead to laboratory testing and notification. This figure is a little down on the previous few years and hopefully this represents increased education to the hotel and tourism industry and to the public in general on the importance of correct food storage and handling and the need to take great care when handling products of animal origin, including eggs.

The small number of meningitis cases is similar to 2001 and much less than 2000 and reflects the success of the immunisation against *Meningococcal C*. The two cases that did occur were of strain B where no immunisation is currently available but research is ongoing. Low meningitis figures also reflect the success of the Hib vaccine. Recently, reduced immunity to *Haemophilus influenzae type B* (Hib vaccine protects against this) has been identified. Accordingly, we are joining with the UK in a catch-up booster campaign in children under the age of 4 to increase immunity against haemophilus influenzae.

Cases of malaria and dysentery were imported and travel is an increasingly common way of acquiring infectious diseases and it is of particular concern following the emergence of the SARS virus.

There were 3 confirmed and notified cases of whooping cough, although there were almost certainly others that were not investigated. Whooping cough is a serious disease in the young unimmunised child but may still cause mild infection after immunisation,and is a cause of persistent coughs in adults, who have either escaped immunisation or whose immunity has waned over the years.

Tuberculosis screening clinic

This clinic continues its important work in immunising *'at risk'* people. These are children who are at risk by virtue of having been born into a family in which there has been tuberculosis or people who are entering employment or travelling to areas where tuberculosis is a significant problem.

Increased publicity regarding tuberculosis has led to a considerable increase in the workload of the clinic, rising from **92** clients in **2001** to **168** in **2002**. Screening has led to the detection of tuberculosis infection before the disease has developed, allowing early treatment and avoiding considerable ill health. There has been concern about the increased incidence of tuberculosis in the UK, but that this has mainly occurred in inner city areas. Rural populations similar to Guernsey have not seen a rise in tuberculosis.

Dr Brian Parkin
Deputy Medical Officer of Health

Sexual Health Clinic - KC60 Reporting - Year 2001 (Part A)

Code	Condition		Male Total	of which homosexually acquired	Female Total
A1, A2	Primary and secondary infectious syphilis	1	0	1	0
A3	Early latent syphilis (first 2 years)	2	0		2
A4, A5, A6	Other acquired syphilis	3	0		0
A7	Congenital syphilis, aged under 2	4	0		0
A8	Congenital syphilis, aged 2 or over	5	0		0
A9	Epidemiological treatment of suspected syphilis	6	1		0
B1, B2	Uncomplicated gonorrhoea	7	8	2	4
B3	Gonococcal ophthalmia neonatorum	8	0		0
B4	Epidemiological treatment of suspected gonorrhoea	9	0		0
B5	Gonococcal complications	10	0		0
C1, C2, C3	Chancroid / LGV / Donovanosis	11	0		0
C4A, C4C	Uncomplicated chlamydia infection	12	19	1	28
C4B	Complicated chlamydia infection	13	0		3
C4D	Chlamydia ophthalmia neonatorum	14	0		0
C4E	Epidemiological treatment of suspected chlamydia	15	19		8
C4H	Uncomplicated non-gonococcal / non-specific urethritis in males	16	34	1	0
C4I	Epidemiological treatment of NSGI	17	3		0
C5	Complicated non-gonococcal / non-specific infection	18	2		1
C6A	Trichomoniasis	19	0		0
C6B	Anaerobic / bacterial vaginosis and male infection	20	0		9
C6C	Other vaginosis / vaginitis / balantis	21	7		0
C7A	Anogenital candidosis	22	9		62
C7B	Epidemiological treatment of C6 and C7	23	0		1
C8, C9	Scabies / pediculosis pubis	24	4	1	0
C10A	Anogenital herpes simplex – first attack	25	1		4
C10B	Anogenital herpes simplex – recurrence	26	8		2
C11A	Anogenital warts – first attack	27	25	2	24
C11B	Anogenital warts – recurrence	28	20	2	25
C11C	Anogenital warts – re-registered cases	29	11		24
C12	Molluscum contagiosum	30	4		2
C13	Antigen positive viral hepatitis B	31	0		0
C14	Other viral hepatitis	32	5		1
D2A	Urinary tract infection	33	0		7
D2B	Other conditions requiring treatment at GUM clinic	34	38		26
D3	Other episodes not requiring treatment	35	83		78
E1A	Asymptomatic HIV infection – first presentation	36	0		0
E1B	Asymptomatic HIV infection – subsequent presentation	37	16	8	6
E2A	HIV infection with symptoms, not AIDS – first presentation	38	0		0
E2B	HIV infection with symptoms, not AIDS – subsequent presentation	39	3	4	0
E3A	AIDS – first presentation	40	0	1	0
E3B	AIDS – subsequent presentation	41	3	4	0
P1A	HIV antibody counselling – with testing	42	204	28	198
P1B	HIV antibody counselling – without testing	43	17		13
P2	Hepatitis B vaccination	44	5	3	3
P3	Family Planning	45	1		11
P4A	Cervical cytology – minor abnormality	46	0	0	3
P4B	Cervical cytology – major abnormality	47	0	0	2
	Total: all conditions		**547**	**40**	**547**

Sexual Health Services - 2002

	First attendance	Subsequent attendance
Total attendances in the quarter – as on KH09 return	**813**	**803**
Incoming telephone calls for clinical advice or results	**Approximately 3,500**	

Attendance at the sexual health clinic continues to increase with a marked increase in new attendances. This increase in workload without subsequent increase in staffing levels and clinic times has resulted in an unsatisfactory compromise in the amount of time that is available for the administration of the department with less time available for the collection, collation and interpretation of data.

Undertaking regular audits allows comparisons with national guidelines, minimum standards and performance indicators so that gaps and weaknesses in service provision can be identified with the aim of amending the service accordingly.

The department strives to see all symptomatic patients within 48 hours of presentation, but this is becoming increasingly difficult to achieve. The consequences of long waiting periods in this area are hard to predict, but the Public Health Laboratory Service states; *'the delay in access time to curative service is important in sexually transmitted infection transmission as this increases the duration of infectiousness (since the individual remains untreated for longer) and increases the probability of disease transmission.'*

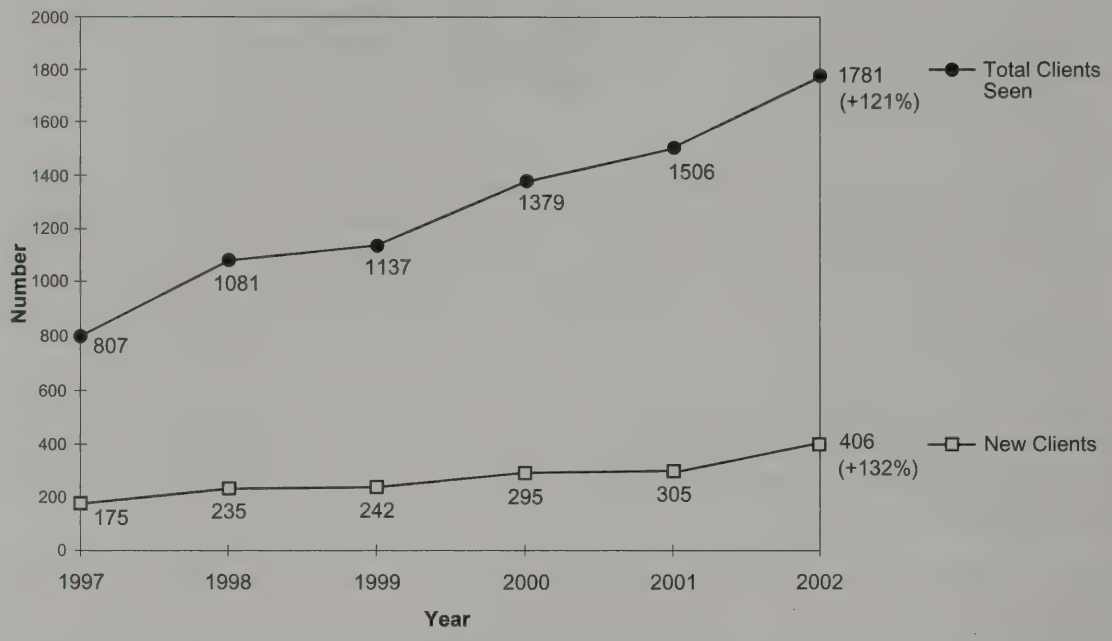
STI's cause considerable reproductive morbidity and poor health outcomes, including *pelvic inflammatory disease* (PID), infertility, ectopic pregnancy, neonatal disorders, cervical cancer and death. **12%** of women with untreated chlamydia develop infertility after a first episode of acute infection, rising to **70%** after three different episodes. There are considerable emotional and financial costs to the consequences of such infection. Often, the only way that women who have been infected by chlamydia can conceive is by expensive assisted fertilisation techniques such as *in vitro fertilisation* (IVF). Chlamydia is the commonest bacterial STI in both the UK and Guernsey and is asymptomatic in **70%** women and **50%** in infected men.

The figures for 2002 show an increase in the cases of gonorrhoea as well as other STI's. Gonorrhoea has long been taken as a marker of sexual health and failure to bring about a reduction in gonorrhoea prevalence indicates a decline in the sexual health of the community.

HIV and AIDS

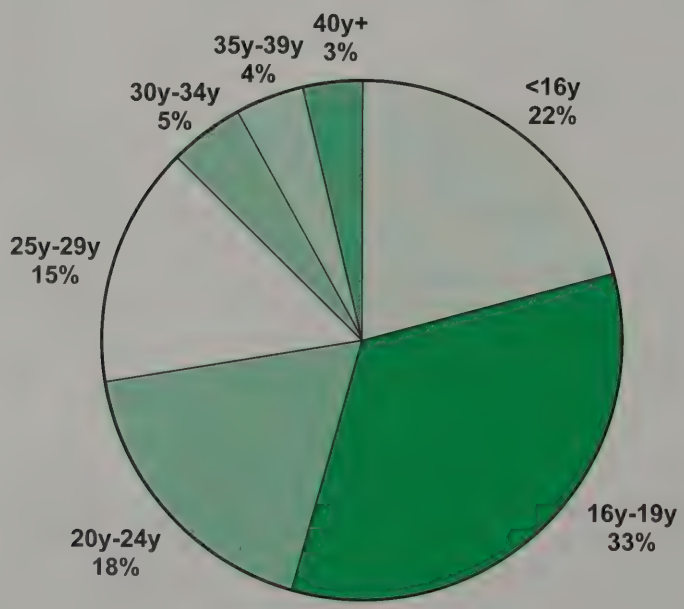
Guernsey continues to experience quantifiable HIV prevalence (**9** men and **2** women in 2002). There were no new diagnoses in 2002, however one patient with HIV under treatment had moved to work here in Guernsey.

Figure 5.3 - Guernsey Family Planning Clinic New and Total Clients seen 1997-2002



Source: Guernsey Family Planning Clinic

Figure 5.4 - Guernsey Family Planning Clinic New Clients by Age - 2002



Source: Guernsey Family Planning Clinic

Unfortunately, 2002 also marked yet another death from AIDS, in a male in whom the route of acquisition was heterosexual intercourse. To date, there have been 8 deaths from HIV (**7** male and **1** female) in Guernsey. There have been larger numbers of new HIV cases in the UK over the last few years, resulting in record numbers of new diagnoses each year.

The average lifetime cost for an HIV positive individual is calculated to be somewhere between £135,000 and £181,000. The prevention of a single onward transmission is estimated to save between £500,000 and £1m in terms of individual health benefits and treatment costs combined. It is important that Guernsey addresses these needs; otherwise it is likely that HIV patients in our community will have both the stigma and social isolation of the disease combined with inequality of their health care provision.

Dr N C King
Sexual Health Clinic

Guernsey Family Planning Service

Rising Attendances

2002 saw a huge increase in the number of young women accessing the service *(figure 5.3)* **275** more consultations were made than in 2001 with the number of new clients rising from **305** to **406**. This was an increase from 2001 of **33.1%** which is nearly ten times the increase seen in the previous year.

All age groups showed an increase in numbers except for the over 40's which remained the same as in 2001 *(figure 5.4)*. The biggest increase was seen in the under 16 age bracket, which is significant as this was the age group that the service targeted through advertising on local radio as well as by working in close conjunction with the school health educators.

Although numbers rose in the 16-19 age bracket, when taken as a proportion of the aforementioned **33.1%**, increase in new clients in the other age groups remained approximately the same with there being a very slight increase in the 35-39 age category and very small decrease in the over 40 age group.

The 'morning after' pill

The year has also seen a debate within the States of Guernsey on the availability of the post-coital contraceptive drug *'Levonelle'*. The Board of Health requested that the Family Planning Service should open every weekday so that *'Levonelle'* can be more readily available.

Figure 5.5 - Guernsey - Births and Terminations of Pregnancy 1994-2002

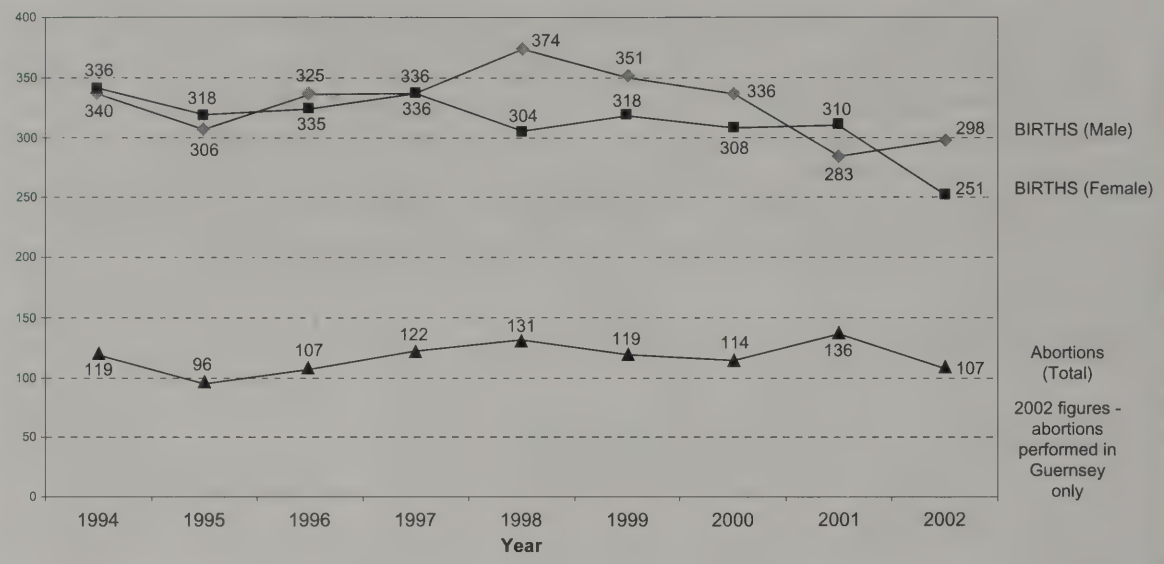
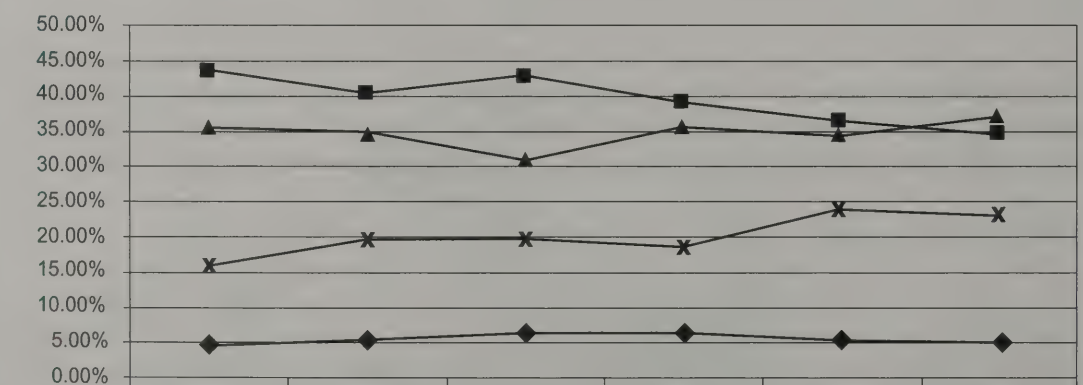


Figure 5.6 - % of Guernsey mothers by age group 1998 - June 2003



	1998	1999	2000	2001	2002	2003
15 - 19	4.50%	5.37%	6.49%	6.39%	5.18%	4.85%
20 - 29	43.63%	40.30%	42.81%	38.99%	36.07%	34.70%
30 - 34	35.83%	34.78%	31.07%	35.80%	34.82%	36.94%
35+	16.04%	19.55%	19.63%	18.82%	23.93%	23.51%

Source: PEH PAS Maternity

This has been achieved from 1st December 2002 and is set to continue into the forthcoming year. The increased media attention following this debate has brought *'Levonelle'* to the forefront of many women's minds, which has been reflected in our figures, showing a **31.9%** increase in the use of this drug. Again, the greatest increase was seen in the under 16's; however, there was little increase in the use of this drug in the over 25's, even though there have been many new clients in this age group. In 2003, we hope to be able to continue this upward trend and carry on making people more aware of the availability of the sexual health service on the island and the importance of these facilities.

Counsellor

The number of clients seeking the advice of the counsellor remains constant, with **34** clients being referred from the specialists, family practitioner surgeries and family planning service in 2002. This is disappointing, as we have seen a three fold increase in positive pregnancy tests from 2001, in the clinic alone, and although all have been offered this free service from the clinic, few have sought counselling. Of the **73** pregnancy tests carried out at the clinic, **24** were positive. On leaving the clinic, **18** of those were undecided as to whether they would continue the pregnancy, but were referred back to their family practitioner.

Mrs Sue le Page
Manager, Guernsey Family Planning Service

Births, Teenage Pregnancies and Abortions

As previously mentioned in Chapter Two - 'Children's Services' - total births in Guernsey continue to fall. The age at which women choose to have children is also rising, and currently a greater proportion of babies (**37%**) are born to women aged 30-34 compared with those age 20-29 (**34.7%**).

The high rate of teenage pregnancies is of great public health concern in Britain, and reducing teenage pregnancies is one of the targets contained in the *'National Sexual Health and HIV Strategy'*. It is pleasing to report that teenage pregnancies (i.e. to mothers <20 years) have fallen for the third successive year and are now some 25% lower than in the year 2000.

Termination of pregnancy on medical grounds may be performed both on and off island. Details of termination of pregnancies lawfully performed locally are collated by the Director of Public Health, whilst those performed in Britain on women normally resident in Guernsey are reported to the Department of Health in London, who in turn notify the island authorities.

Unfortunately, a change in Departmental computers in London means that information on terminations performed off island were not available at the time of this Report. There were **107** terminations lawfully performed locally during 2002, (compared with **110** in 2001). Providing there was no increase in terminations performed off island, then it would seem unlikely that there has been an increase in overall numbers of abortions performed. A full analysis will be published in the 105th annual MoH Report.

Appendix 1

Guernsey and Alderney Vital Statistics 2002

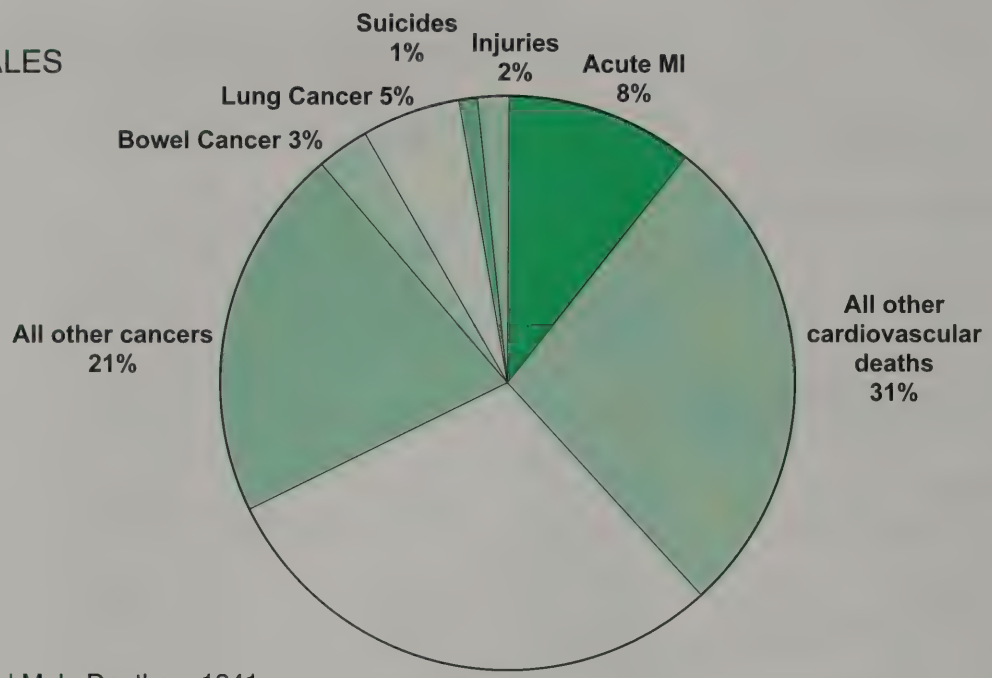
A1.1 Guernsey - Vital Statistics 2002

Births and Birth-related Data

	Guernsey 2002	Guernsey 5 Year Mean 1994-1998	England & Wales 2001
Estimated Mid Year	59,807	58,867	52,943,000
Resident Population:			
• Males	29,138	28,297	26,142,000
• Females	30,669	30,570	26,801,000
• M : F	0.95	0.93	0.98
Population Density [Area 63.1Km²]:	948	933	51.8
Marriages:	371	345	263,500
• Marriages/000	6.2	5.9	5.0
Divorces:	196	165	144,600
• Divorces/000	3.2	2.8	2.7
Divorces : Marriages	0.53	0.48	0.55
Births:	549	662	594,360
• Males	298	337	304,489
• Females	251	323	289,871
• M : F	1.2	1.04	1.05
Births outside Marriage:	185	182	238,086
• % All Births	33.7%	28%	39.5%
Stillbirths:	2	4.2	3,159
• Rate/000 Live Births	3.6	6.3	5.3
Early Neonatal deaths: (0-6 days)	0	n/a	1,600
Late Neonatal deaths: (7-27 days)	0	2.2	1,246
Infant Deaths:(<1 year)	2	3	3,267
• Infant Death Rate/000	3.6	4.5	5.6
Crude Birth Rate/000	9.2	11.2	11.4
Natural Increase per annum:	-0.02%	+0.20%	+0.13%

Deaths in Guernsey - By Cause 1998-2002

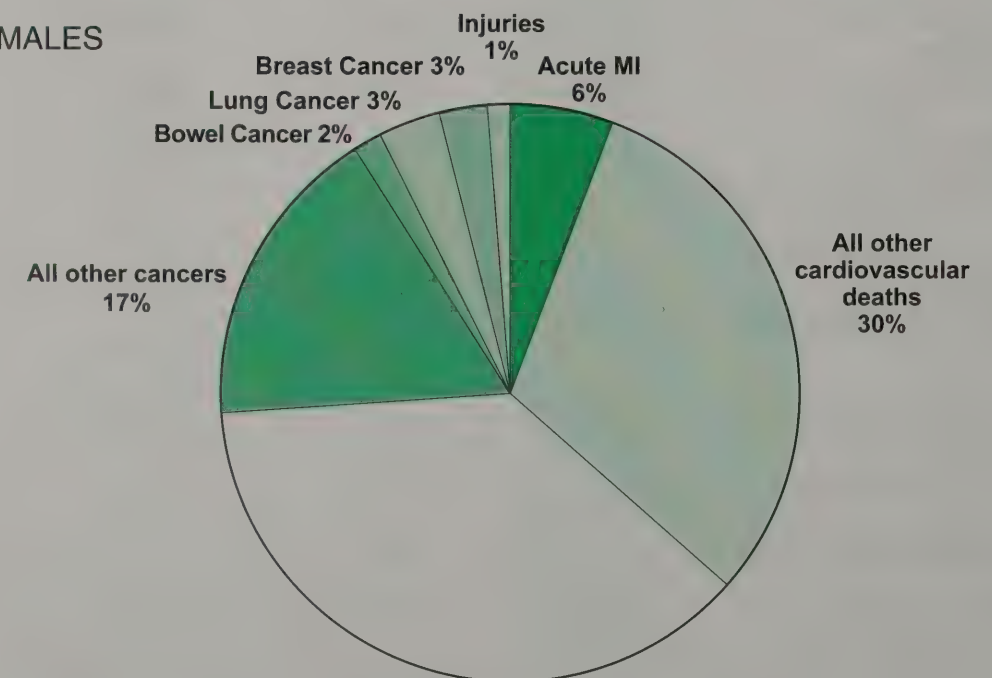
MALES



Total Male Deaths = 1341

Deaths in Guernsey - By Cause 1998-2002

FEMALES



Total Female Deaths = 1431

Source: MoH Reports 1998-2002

A1.2 Guernsey - Vital Statistics 2002

Deaths and Death-related Data

	Guernsey 2002	Guernsey 5 Year Mean 1994-1998	England & Wales 2001
Total Deaths:	563	592	535,600
• Males	281	289	255,500
• Females	282	305	280,100
• M : F	1.01	0.95	0.91
Crude Death Rate:/000	9.4	10.1	10.1
Circulatory Deaths (I00-I99):	183		266,720
• Males			
- Rate/00,000	336	406	359
• Females			
- Rate/00,000	277	388.6	218
Cancer Deaths (C00-C97/D00-D48):	115		138,313
• Males			
- Rate/00,000	230	298	243
• Females			
- Rate/00,000	157	261	167
Lung Cancer Deaths (C34):	21		30,199
• Males			
- Rate/00,000	34	79	64
• Females			
- Rate/00,000	36	38.6	30
Breast Cancer Deaths (C50):	6		11,759
• Females			
- Rate/00,000	20	42.5	43
Alcoholic Liver Disease (K70) (K74):	0		4,494
• Males			
- Rate/00,000	0	12.7	11
• Females			
- Rate/00,000	0	7.9	6.0
Injury Deaths (incl suicide) (S00-X59):	7		12,483
• Males			
- Rate/00,000	21	42	38
• Females			
- Rate/00,000	3.3	17.1	15
Suicide Deaths (X60-X84):	8		3,614
• Males			
- Rate/00,000	10.3	12.7	11.0
• Females			
- Rate/00,000	0	6.5	3.0

Source: Office of Health Economics *'Compendium of Health Statistics'* (13th Edition 2001)

A1.3 GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS - 2002

ICD10 Code No	Cause of Death	Total		Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	Group I Infectious and parasitic diseases																
A41	Other Septicaemia	5	7	0	0	0	0	0	0	0	0	1	0	0	1	4	6
	Total Group I	5	7	0	0	0	0	0	0	0	0	1	0	0	1	4	6
	Group II Neoplasms																
C15	Malignant neoplasm of oesophagus	5	0	0	0	0	0	0	0	0	0	3	0	1	0	1	0
C16	Malignant neoplasm of stomach	4	0	0	0	0	0	0	0	2	0	0	0	0	0	2	0
C18	Malignant neoplasm of colon	11	7	0	0	0	0	0	0	0	0	2	1	1	0	8	6
C20	Carcinoma of the rectum	2	2	0	0	0	0	0	0	0	0	0	0	0	1	2	1
C22	Malignant neoplasm of liver & intrahepatic bile duct	2	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0
C25	Malignant neoplasm of pancreas	6	1	0	0	0	0	0	0	0	0	1	0	2	0	3	1
C32	Malignant neoplasm of larynx	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
C34	Malignant neoplasm of bronchus and lung	10	11	0	0	0	0	0	0	0	0	6	1	1	1	3	9
C41	Malignant neoplasm of bone and articular cartilage of other and unspecified sites	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0
C43	Malignant melanoma of skin	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
C45	Mesothelioma	3	0	0	0	0	0	0	0	0	0	0	0	1	0	2	0
C50	Malignant neoplasm of breast	0	6	0	0	0	0	0	0	0	0	0	0	0	1	0	5
C52	Malignant neoplasm of vagina	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
C53	Malignant neoplasm of cervix uteri	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0
C55	Malignant neoplasm of uterus, part unspecified	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2
C56	Carcinoma of the ovary	0	6	0	0	0	0	0	0	0	0	0	0	0	1	0	5
C61	Carcinoma of the prostrate	8	0	0	0	0	0	0	0	0	0	3	0	2	0	3	0
C64	Malignant neoplasm of kidney, except renal pelvis	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
C67	Malignant neoplasm of bladder	1	2	0	0	0	0	0	0	0	0	1	0	0	1	0	1
C68	Malignant neoplasm of other & unspecified urinary organs	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
	c/f	56	41	0	0	0	0	0	0	2	2	19	2	9	5	26	32

A1.3 GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS - 2002

ICD10 Code No	Cause of Death	Total		Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	b/f	56	41	0	0	0	0	0	0	2	2	19	2	9	5	26	32
C71	Malignant neoplasm of brain	2	2	0	0	0	0	0	0	0	1	1	0	1	1	0	0
C73	Malignant neoplasm of thyroid gland	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
C78	Malignant neoplasm of adrenal gland	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
C79	Secondary malignant neoplasm of other sites	4	1	0	0	0	0	0	0	0	0	1	1	1	0	2	0
C80	Malignant neoplasm without specification of site	3	1	0	0	0	0	0	0	0	0	2	0	0	0	1	1
C81	Hodgkin's disease	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
C85	Other & specified types of non-Hodgkin's lymphoma	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0
C91	Lymphoid leukaemia	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
	Total Group II	67	48	0	0	0	0	0	0	2	3	24	3	12	7	29	35
	Group III Diseases of blood & blood-forming organs & certain disorders involving the immune mechanism																
D46	Myelodysplastic syndromes	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
D75	Other diseases of blood and blood-forming organs	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	Total Group III	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2
	Group V Mental and behavioural disorders																
F03	Unspecified dementia	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	Total Group V	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	Group VI Diseases of the nervous system																
G12	Spinal muscular atrophy and related syndromes	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
G30	Alzheimer's disease	1	1	0	0	0	0	0	0	0	0	0	0	0	1	1	0
G93	Other disorders of brain	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	Total Group VI	1	3	0	0	0	0	0	0	0	0	0	1	0	1	1	1

A1.3 GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS - 2002

ICD10 Code No	Cause of Death	Total		Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	Group IX Diseases of the circulatory system																
I21	Acute myocardial infarction	29	15	0	0	0	0	0	0	1	0	7	0	8	3	13	12
I24	Other acute ischaemic heart disease	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
I25	Chronic ischaemic heart disease	5	0	0	0	0	0	0	0	0	0	1	0	1	0	3	0
I26	Pulmonary embolism	5	5	0	0	0	0	0	0	0	0	0	0	1	1	4	4
I27	Other pulmonary heart diseases	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
I42	Cardiomyopathy	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
I44	Atrioventricular and left bundle-branch block	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
I46	Cardiac arrest	11	8	0	0	0	0	0	0	0	0	0	0	3	2	8	6
I49	Other cardiac arrhytyhmias	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
I50	Heart failure	19	26	0	0	0	0	0	0	0	0	2	1	4	2	13	23
I60	Subarachnoid haemorrhage	2	3	0	0	0	0	0	0	1	0	1	1	0	0	0	2
I61	Intracerebral haemorrhage	4	2	0	0	0	0	0	0	0	0	1	0	0	1	3	1
I62	Other nontraumatic intracranial haemorrhage	2	1	0	0	0	0	0	0	1	0	0	0	1	1	1	0
I63	Cerebral infarction	3	2	0	0	0	0	0	0	0	0	0	1	3	0	0	1
I64	Stroke (or cerebrovascular accident)	9	13	0	0	0	0	0	0	0	0	2	0	0	0	7	13
I66	Occlusion and stenosis of cerebral arteries, not resulting in cerebral infarction	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
I67	Other cerebrovascular diseases	6	5	0	0	0	0	0	0	0	0	0	0	1	0	5	5
I71	Aortic aneurism and dissection	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
I73	Other peripheral vascular diseases	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1
	Total Group IX	98	85	0	0	0	0	0	0	2	0	14	4	24	10	58	71
	Group X Diseases of the respiratory system																
J18	Pneumonia	60	68	0	0	0	0	0	0	1	0	3	1	10	8	46	59
J43	Emphysema	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
J44	Other chronic obstructive pulmonary disease	4	2	0	0	0	0	0	0	0	0	0	0	1	2	3	0
J45	Asthma	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
J47	Bronchiectasis	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
J84	Other interstitial pulmonary diseases	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
J96	Respiratory failure, not elsewhere classified	10	13	1	0	0	0	0	0	0	0	1	2	4	2	4	9
J98	Other respiratory disorders	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
	Total Group X	77	85	1	0	0	0	0	0	1	0	4	3	15	12	56	70

GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS - 2002

ICD10 Code No	Cause of Death	Total		Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	Group XI Diseases of the digestive system																
K26	Duodenal ulcer	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
K55	Vascular disorders of intestine	2	2	0	0	0	0	0	0	0	0	1	0	0	0	1	2
K65	Peritonitis	2	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0
K72	Hepatic failure, not elsewhere classified.	1	2	0	0	0	0	0	0	0	0	1	1	0	1	0	0
K92	Other diseases of digestive system	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	3
	Total Group XI	5	8	0	0	0	0	0	0	0	0	4	1	0	1	1	6
	Group XIII Diseases of the muscoskeletal system and connective tissues																
M80	Osteoporosis with pathological fracture	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
	Total Group XIII	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
	Group XIV Diseases of the genito-urinary system																
N17	Acute renal failure	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	4
N18	Chronic renal failure	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
N19	Unspecified renal failure	6	4	0	0	0	0	0	0	0	0	0	1	1	0	5	3
	Total Group XIV	7	9	0	0	0	0	0	0	0	0	0	1	1	0	6	8
	Group XVI Certain conditions originating in the perinatal period																
	Disorders related to short gestation and low birth weight, not elsewhere classified	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
	Still birth	2	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total Group XVI	3	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0

A1.3 GUERNSEY - DEATHS BY ICD 10 CODE AND AGE GROUPS - 2002

ICD10 Code No	Cause of Death	Total		Under 1		Age 1-14		Age 15-24		Age 25-44		Age 45-64		Age 65-74		Age 75+	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	Group XVIII Symptoms, signs & abnormal clinical & laboratory finding, not elsewhere classified																
R09	Other symptoms and signs involving the circulatory	1	4	0	0	0	0	0	0	0	1	0	0	0	0	1	3
R54	Old age (senility)	8	25	0	0	0	0	0	0	0	0	0	0	1	0	7	25
R57	Shock, not elsewhere classified	2	3	0	0	0	0	0	0	0	1	2	0	0	0	0	1
R64	Cachexia	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	Totals Group XVIII	11	33	0	0	0	0	0	0	0	2	2	1	1	0	8	30
	Group XX External causes, morbidity & mortality																
V03	Pedestrian injured in collision with car, pick-up truck or van	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
V23	Motorcycle rider injured in collision with car, pick-up truck or van	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
W79	Inhalation and ingestion of food causing obstruction of respiratory tract	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
X08	Exposure to other specified smoke, fire and flames	0	1	0	0	0	0	0	1	0	0	0	0	0	1	0	0
X67	Intentional self-poisoning by and exposure to other gases and vapours	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
X70	Intentional self-harm by hanging, strangulation and suffocation	2	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
	Totals Group XX	6	1	0	0	0	0	1	0	2	0	2	0	0	1	1	0
	Total Deaths:	**281**	**282**	**4**	**0**	**0**	**0**	**1**	**0**	**7**	**5**	**51**	**14**	**54**	**33**	**164**	**230**

A1.4 Alderney Vital Statistics - 2002

	Males	Females	Total 2002	Total 2001
Population (2001 Census):	1,137	1,157	**2,294**	2,294
• **M : F**			**0.98**	0.98
Births - In Guernsey:	6	4	**10**	10
Births - In Alderney:	1	3	**4**	0
Total Births to Alderney residents:	7	7	**14**	10
Births outside marriage:	2	2	**4**	5
Crude Birth Rate/000	-	-	**6.1**	4.4
Marriages registered in Alderney:			**14**	8
Deaths registered in Alderney:	15	6	**21**	17
Crude Death Rate/000			**9.2**	7.4
Natural Increase:*			**-7 [-0.3%]**	-7 [-0.3%]

*The natural increase is the difference between the crude birth rate and the death rates expressed as a percentage of the resident population.

Appendix Two

2.1 Staff providing public health services 2002

Director of Public Health/Medical Officer of Health
Dr David Jeffs FRCP FAFPHM MFPH FRSH

Personal Assistant
Mrs Yvonne Kaill *(from January 2002)*

Part-time Medical Staff:

Deputy Medical Officer of Health
Dr Brian Parkin MB BS BSc MRCP MRCGP DRCOG

Sexual Health Clinic
Dr Nicholas King LRCP MRCS MBBS

Environmental Health Department:

Chief Environmental Health Officer
Mr John Cook MCIEH

Deputy Chief Environmental Health Officer
Mr Tony Rowe MCIEH

Environmental Health Officers
Mr Stan Horton MCIEH
Mr Stuart Wiltshire MCIEH
Mr Jonathon Coyde MCIEH
Mr Tobin Cook MSc MCIEH
Mrs Mhairi Macgregor BSc (Hons)

Waste Regulation Officer
Mr Simon Welch BSc MCIWM

Pest Control Operatives
Mr Paul Tostevin
Mr Michael Brache

Secretary
Mrs Marilyn Bougourd *(acting since October 2001)*

Health Promotion Unit:

Health Promotion Manager
Miss Yvonne Le Page BEd(Hons) DipHE&HP

Health Promotion Officer (smoking and heart disease)
Mrs Gerry Le Roy RGN

Health Promotion Assistant (cancer)
Mrs Lucy Whitman MSc

Resources Officer
Mrs Stephanie Charlwood

Secretary
Mrs Bella Mahy

Health Strategy Unit:

Clinical Risk Manager
Mrs Jean Ellyatt RGN, SCM, CMS, Cert MHS

Clinical Audit Nurse
Miss Morag Fitzpatrick RGN, Dip He

Healthcare Information Manager
Mrs Allyson Huntington

Healthcare Information Analysts
Mrs Helen Jones BSc (Hons) *(until August 2002)*
Mr Paul Falla

Health databases
Mrs Jenny Elliott

Clinical Coders:

Senior Clinical Coder
Mrs Margaret Cann, ACC

Clinical Coder
Mrs Sue Sheppard